ZAMBIA INTEGRATED SYSTEMS STRENGTHENING PROGRAM

ANNUAL REPORT
JANUARY- DECEMBER 2011

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ACRONYMS

AID	Active Infection Detection
AIDS	Acquired Immunodeficiency Syndrome
APS	Annual Program Statement
BCC	Behavioral Change Communication
CBGMP	Community Based Growth Monitoring and Promotion
CCS	Clinical Care Specialists
CCT	Clinical Care Team
CDC	Center for Diseases Control
CEDPA	Centre for Development and Population Activities
CHA	Community Health Assistant
CHC	Community Health Coordinator
CHW	Community Health Worker
CO	Contracting Officer
CP	Cooperating Partner
DEMS	Direct Entry Midwifery Schools
DHO	District Health Office
DHIO	District Health Information Officer
DMO	District Medical Officer
EGPAF	Elizabeth Glazer Pediatric AIDS Foundation
EHT	Environmental Health Technicians
EHO	Environmental Health Officers
EMMP	Environmental Mitigation and Monitoring Plan
EmONC	Emergency Obstetric and Newborn Care
FANC	Focused Antenatal Care
F&A	Finance and Administration
FP	Family Planning
GIS	Geographical Information System
GPS	Global Positioning System
GRZ	Government of Zambia
GST	Grant Support Team
HBLSS	Home-based Life Saving Skills
HCAC	Health Center Advisory Committee
HCM	Human Capital Management
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HRM	Human Resource Management
HSSP	Health Services and Systems Program
IMaD	Improving Malaria Diagnostics

IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Preventive Therapy
IRMTWG	National Insecticide Resistance Management Technical Working Group
IRS	Indoor Residual Spraying
IVM	Integrated Vector Management
IYCF	Infant and Young Child Feeding
LLIN	Long Lasting Insecticidal Net
LTFP	Long Term Family Planning
MIS	Malaria Indicator Survey
MLA	Management and Leadership Academy
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MOP	Malaria Operational Plan
MOU	Memorandum of Understanding
MNCH	Maternal Newborn and Child Health
MS	Management Specialist
MSL	Medical Stores Limited
MTC	Malaria Transmission Consortium
NHC	Neighborhood Health Committee
NHSP	National Health Strategic Plan
NIPA	National Institute for Public Administration
NMCC	National Malaria Control Centre
NFNC	National Food and Nutrition Commission
PA	Performance Assessment
PDA	Personal Digital Assistant
PHO	Provincial Health Office
PMEC	Payroll Management Establishment Control
PMEP	Performance Monitoring and Evaluation Plan
PMI	President's Malaria Initiative
PMP	Performance Management Package
PMTCT	Prevention-of-Mother-to-Child Transmission (of HIV)
PPAZ	Planned Parenthood Association of Zambia
PPP	Public Private Partnership
PSMD	Public Service Management Division
QI	Quality Improvement
RDL	Radio Distance Learning
RDT	Rapid Diagnostic Test
RED	Reach Every Child in Every District
RFA	Request for Applications
RH	Reproductive Health
SHARe	Support to the HIV/AIDS Response
SMAG	Safe Motherhood Action Group
TSS	Technical Support Supervision
UNZA	University of Zambia

USAID	United States Agency for International Development
WHO	World Health Organization
WISN	Workload Indicators for Staffing Needs
ZHWRS	Zambia Health Worker Retention Scheme
ZISSP	Zambia Integrated Systems Strengthening Program
ZPCT	Zambia Prevention Care and Treatment

EXECUTIVE SUMMARY

This report provides an account of program implementation under the Zambia Integrated Systems Strengthening Program (ZISSP) during the period January 1 to December 31, 2011. It highlights achievements made through close collaboration with the Zambian Ministry of Health (MOH). The report also notes challenges experienced, as well as the plans for 2012.

In support of the central MOH program, the following were the key achievements:

- Under the Zambia Health Workers Retention Scheme, ZISSP supported the retention allowances for 119 workers in the project's 27 target districts. A new performance management system was introduced, i.e., the Annual Performance Appraisal System. The MOH also implemented the Performance Management Package in order to improve accountability and efficiency in the public sector. The Human Resources Information System report was finalized which not only described the Ministry's Human Resource Management processes, but also identified the costs and necessary steps required to update the existing Payroll Management and Establishment of Control System.
- ZISSP supported the MOH to train 37 health care workers from Northern and Western Provinces in long-term family planning method (21 were male and 16 were female). ZISSP also provided technical and financial support to develop the Adolescent Health strategy.
- ZISSP identified 148 potential emergency obstetric and newborn care (EmONC) sites in the 27 target districts. ZISSP developed the EmONC training plan, identified the number of health care providers to be trained per district, and set the training schedule and post-training follow-up for the period 2011 - 2014. In the third and fourth quarters of 2011, ZISSP worked with MOH to train 135 health care workers and nurse tutors in EmONC.
- In 2011, ZISSP provided technical and financial support to train 123 health care workers from five districts (Luangwa, Chongwe, Mambwe, Nyimba, Lundazi, and Mkushi) across three provinces (Lusaka, Central and Eastern provinces) in integrated management of childhood. ZISSP also provided support for a post-training initial follow-up visit of 96 of the 123 participants.
- ZISSP trained 150 community members from Solwezi, Mwinilunga, Ikelenge, Mbala, Mpika and Masaiti districts in infant and young child feeding and community-based growth monitoring and promotion within a three-month period. ZISSP trained 73 health care workers from three districts (Mwinilunga, Mbala, and Masaiti) in IYCF.

In malaria:

- ZISSP trained 105 district-level trainers in IRS techniques, implementation and supervision. This was followed by support to 35 districts to train 1,888 spray operators.
- ZISSP conducted entomological investigations for pyrethroids and DDT in Copperbelt, North-Western and Northern provinces, and carbamates in Eastern Province. The resistance data from the selected districts show that anopheles gambiae is resistant to DDT and most of the pyrethroids (Permethrin, Deltamethrin and Lambdacyhalothrin) are

susceptible to carbamates and organophosphates. The MOH used the data to select alternative chemicals in the areas where resistance was detected.

- Furthermore, ZISSP trained 20 supervisors and 96 enumerators from five districts to geo-code household enumeration data using personal digital assistants (PDA). Five districts subsequently completed the geo-coding process: Mpulungu, Samfya, Chibombo, Chiengi and Mwense. ZISSP supported the five districts and the National Malaria Control Center to mine the data from the PDAs and developed a report that was shared with USAID.

In the clinical care technical area, some of the key highlights from 2011 are as follows:

- ZISSP supported the MOH in developing the first quality improvement operational guideline, review and harmonization of the training package which included the facilitator and participant manuals as well as the power point slides.
- ZISSP assisted the MOH in reviewing the clinical mentoring curriculum and operational guidelines as a result of MOH identifying the need to mentor primary health care workers because they rarely had anyone to consult with when faced with difficult and challenging health conditions.
- PHO with support from the ZISSP Clinical Care Specialists (CCSs) established multi-disciplinary Clinical Care Teams (CCTs) in eight provinces and 68 districts; these multi-disciplinary CCTs are comprised of the clinicians, nurses, health information officers, pharmacists, nutritionists and laboratory personnel.
- With ZISSP support, the provincial and district CCTs conducted 1,184 mentorship sessions in eight out of nine provinces by the end of 2011. A total of 998 health workers were mentored (460 females and 538 males) in various clinical areas.

The ZISSP community team accomplished the following:

- Successfully completed a community resource mapping exercise, the results of which will be used to guide ZISSP's community level interventions.
- Participated in revising the Health Center, Health Post and Community Planning Handbook aimed at strengthening community involvement in health planning.
- Provided support to the MOH to develop and implement its Community Health Worker strategy.
- Supported formative research in specific community communication initiatives to provide relevant sources of primary data required in developing national communication materials.
- Completed key documents that will guide the implementation of the grants program and established the Grants Support Teams at national, provincial and district levels.

The ZISPP Management Specialist:

- Engaged in activities to strengthen the capacity of the MOH provincial and district level staff in program planning and budgeting.
- Introduced the Cooperating Partners Meetings which are aimed at strengthening partner collaboration at provincial and district levels.

- Together with ZISSP's subcontractor BroadReach Institute of Training for Education (BRITE), worked with the MOH to adapt the management and leadership academy curriculum to the Zambian context and initiated training.

Some of the highlights under the Monitoring and Evaluation Unit included the developing of the Performance Monitoring and Evaluation Plan (PMEP) and its successful implementation. The Unit also developed data collection tools. The Capacity Building Specialist developed training curricula that supports training and provided support to the Community Health Assistant program.

The year was not without its challenges among which were delays in filling key positions, for example, the Clinical Care Specialists in three provinces and a Monitoring and Evaluation Officer. The malaria unit experienced a major setback when there was a delay by the MOH to release operational funds for the 2011 IRS campaign. The inability of ZISSP to pay out-of-pocket allowances during training also adversely affected implementation of some planned training activities.

ZISSP Achievements: January 1, 2011 to December 31, 2011

Indicator	Work Plan		Annual Achievements (January–December 11)			
	Targets (June 10 – December 14)	Targets (October 2010 – September 2011)	Achievements (January – December 2011)	Male	Female	Total
Proportion of the health care workers supported through the ZHWRS in 27 target districts retained for the first and second year (cohort)	119	119	117	77	40	117
Number of facility providers trained in FP/RH counseling, service delivery, and/or guidelines	192	82	37	21	16	37
Number of community-based providers trained in FP/RH counseling, service delivery, and/or guidelines	TBD	540	0	0	0	0
Number of health care facility providers trained in maternal/newborn health….[i]	540	237	200	76	59	135
Number of community health volunteers trained in maternal/ newborn health….[ii]	729,000 [iii]	N/A	374	221	153	374
Number of children under 12 months of age who received DPT3 from USG-supported programs	2,047,000	398,000	512,000 (as of June 2011)	NA	NA	NA
Number of children under 5 years of age who received Vitamin A from USG-supported programs	12,350,000	2,383,000	1,893,467 (as of June 2011)	NA	NA	NA
Number of community-level health workers trained in child health and nutrition	TBD	120	288	189	99	288
Number of health care providers trained in child health care and child nutrition through USG-supported health area programs	432	96	607	261	346	607
Number of housing units and structures sprayed with IRS with USG funds	2,300,000	1,459,948	Data by March 2012	-	-	-
Proportion of targeted structures sprayed with IRS with USG funds	85%	85%	Data by March 2012	-	-	-

Indicator	Work Plan		Annual Achievements (January–December 11)			
	Targets (June 10 – December 14)	Targets (October 2010 – September 2011)	Achievements (January – December 2011)	Male	Female	Total
Number of women who have completed a pregnancy in the last two years that received two or more doses of IPTp	85%	75%	MIS data in 2012	-	-	-
Proportion of children under 5 years with suspected malaria that received treatment with ACT within 24 hours of onset of their symptoms	70%	40%	MIS data in 2012	-	-	-
Proportion of households with at least one ITN and/or sprayed with IRS in the last 12 months	85%	80%	MIS data in 2012	-	-	-
Number of health workers trained in malaria case management with USG funds	TBD	360	627	395	232	627
Number of health workers trained in FANC	TBD	360	38	14	24	38
Number of people (PMOs, DMOs, Drivers, store keepers, IRS supervisors and spray operators) who have been trained with USG funds to deliver IRS (disaggregated by type of training)	13,567	2,396	1,888 [v]	1279	609	1888
Number of community health workers or volunteers trained in malaria case management or prevention with USG funds	1,296	540	77	70	7	77
Number of health care workers that successfully complete an in-service training program within the reporting period (clinical mentoring sessions disaggregated by gender)	2,400[i]	600	1083[ii]	528	473	1001[iii]
Number of health care workers that successfully complete an in-service training program within the reporting period (management and leadership, planning, HR –PMP, data quality by gender) **HSS**[iv]	800	240	626	389	237	626

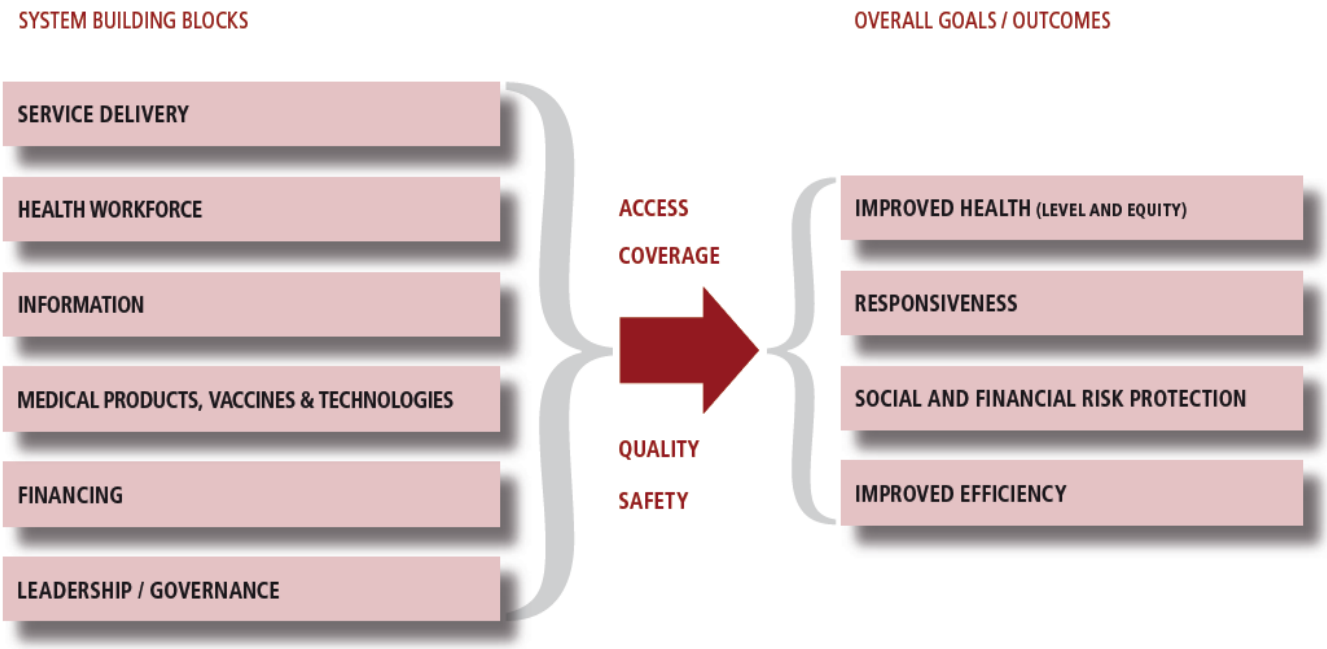
1. INTRODUCTION

This report presents (ZISSP's performance progress during the period January 1st to December 31, 2011. The report outlines the key program achievements and the challenges experienced during implementation.

ZISSP seeks to increase the use of high-impact health services through a health systems strengthening approach. ZISSP views health systems strengthening from the perspective of the World Health Organization's concept of six building blocks that comprise the system. ZISSP works to strengthen the individual building blocks and the linkages between the blocks. The intent is to improve the six health system building blocks and manage their interactions in ways that achieve more equitable and sustained improvements across health services and health outcomes.

ZISSP focuses primarily on service delivery, the health workforce, information, and leadership and governance. In its work in each building block, the project seeks to address the drivers of health system performance: inputs, policies & regulations, organizational structure, and the behavior of health system actors.

Figure 1: WHO Health System Building Blocks



ZISSP works very closely with the Ministry of Health (MOH) to support activities in the National Health Strategic Plan (NHSP) and annual action plan.

In addition, ZISSP works at all levels of the health system – that is the national (MOH – Central Office), provincial, district and community – to build capacity to deliver high impact health services and to improve the use of health services.

1.1 PROGRAM OBJECTIVES

ZISSP's overarching goal is to work with the MOH to nurture sustained improvements in management of the health system while also increasing the utilization of high-impact health services.

1.2 TECHNICAL AREAS

ZISSP focus areas include HIV/AIDS, malaria, family planning, and maternal health, newborn and child health and nutrition. The program strengthens policies, resource management, and service delivery systems across these interrelated public health programs. As a result of ZISSP interventions, more families and individuals in selected districts in Zambia are expected to utilize the services and receive the information required for them to attain and maintain good health.

1.3 ORGANIZATION OF ZISSP ACTIVITIES

ZISSP organizes its activities under the following four tasks:

Task 1: Strengthen the ability of the MOH at the national level to plan, manage, supervise and evaluate delivery of health services nationwide.

Task 2: Improve management and technical skills of health providers and managers in provinces and districts in order to increase the quality and use of health services within target districts.

Task 3: Improve community involvement in the provision and utilization of health services in targeted areas.

Task 4: Ensure service delivery and other activities are effectively integrated at all appropriate levels in the health system through joint planning and in-kind activities with partners and appropriate public private partnerships (PPP).

1.4 STRATEGIC APPROACH

ZISSP provides technical support and capacity building to the MOH to enable the achievement of its program results. To achieve results under each task, ZISSP has adopted the following five main strategies:

- Use a whole-system approach to remove obstacles and strengthen the delivery and utilization of essential services.
- Build Zambian capacity as the foundation for sustainability.
- Increase impact through partner engagement and integration.
- Plan from the "bottom-up" in order to ensure relevance and participation.
- Ensure gender integration.

1.5 THE ZISSP TEAM

ZISSP is led by Abt Associates Inc., which works in partnership with Akros Research, the American College of Nurse Midwives (ACNM), Banyan Global, Broad Reach Institute for Training and Education (BRITE), the Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs

(CCP), Liverpool School of Tropical Medicine (LSTM), and the Planned Parenthood Association of Zambia (PPAZ).

2. TASK ONE: SUPPORT FOR THE CENTRAL MINISTRY

2.1 HUMAN RESOURCE FOR HEALTH

2.1.1 ZAMBIA HEALTH WORKERS RETENTION SCHEME

ZISSP is working with the MOH to improve the administrative and financial management of the Zambia Health Worker Retention Scheme (ZHWRS). The current scheme requires management assistance and funding of available retention posts. Out of the 1,550 available posts, the MOH and its partners have filled 991. ZISSP supports the retention allowances for 119 workers (27 medical officers, 80 nurses, and 12 clinical officers) of these 40 are females and 77 males in the project's 27 target districts.

In quarter two, ZISSP drafted a ZHWRS Memorandum of Understanding (MOU) with the MOH, which was subsequently approved by the Ministry of Justice. ZISSP was then able to move forward with its commitment to the human resources for health (HRH) strategic plan of retaining health professionals in rural areas. ZISSP updated the ZHWRS database and payroll and prepared contracts for new entrants to the scheme. ZISSP disbursed a total of ZMK2, 357, 030, 880 to the MOH to reimburse the ZHWRS basket for 119 health care workers for the period January to September 2011. However, as of December 2011, only 117 health workers were on the scheme. The ZISSP-supported ZHWRS administrator assisted the MOH to transfer ZHWRS data for 991 participants to Excel in order to convert the database into Navision. This new system will simplify management of the ZHWRS data and generating the payroll.

2.1.2 PERFORMANCE MANAGEMENT PACKAGE

The MOH began to implement the Performance Management Package (PMP) in the health sector in 2010 The Government of Zambia (GRZ) also designed an overarching PMP to improve accountability and efficiency in the public sector. The PMP seeks to identify and develop required knowledge and management skills to improve the performance of civil servants. In 2011, ZISSP developed an implementation plan for the PMP and later supported the implementation of the plan by training 134 trainers from the central and provincial levels and 280 staff from Copperbelt, Luapula, Eastern, Western, Northern and Central Provinces as part of the PMP roll out to provinces and districts. ZISSP also funded two workshops to develop job descriptions for staff positions. The Public Service Reform Package (PSRP) introduced the Annual Performance Appraisal System as a new performance management mechanism.

2.1.3 CAPACITY ASSESSMENT

ZISSP conducted a capacity needs assessment for HR staff, which identified weaknesses and documented possible solutions and growth opportunities to move MOH HR and registry staff performance in a new direction. Some of the challenges cited during the assessment were the ineffective and inefficient HR and

records management at all levels. To address this, the assessment recommendations suggested that HR personnel need to develop a culture of reading and reviewing the policies and creating opportunities for consultations on interpretation of policy documents. Further, all registry staff need to be trained in records management. The recommendations of the assessment enabled the MOH to decentralize certain functions to the provincial level. The functions decentralized include: appointments, confirmations, retirements, resignations and transfers within the province.

2.1.4 HUMAN RESOURCE INFORMATION SYSTEM

ZISSP finalized a report on the Human Resource Information System (HRIS) in June 2011 that described the Ministry's Human Resources Management (HRM) processes and identified the costs and steps necessary to update the existing Payroll Management and Establishment Control System (PMEC) modules of the Human Capital Management (HCM) suite and add important new modules as well as additional user licenses. The HRIS report also described the necessary steps to enable the MOH to have direct access to PMEC data. To improve operational and strategic planning, the MOH needs direct access to its own payroll data so that it can have up-to-date HR information and provide statistical reports on staff turnover, recruitment, retirement, vacancies and establishment schedules per health facility.

2.1.5 HUMAN RESOURCE MANAGEMENT

ZISSP supported two MOH staff to participate in the Harvard training on "Strengthening Human Resources for Health". This experience provided the participants with new and innovative ways of addressing human resource policy and management issues. The course also provided the participants with a forum to share experiences with HR managers from other countries on country specific initiatives to resolve HR problems. The participants recommended that senior officers at the MOH and PSMD be provided an opportunity to attend the course each year.

2.1.6 INTRODUCTION OF THE WORKLOAD INDICATORS FOR STAFFING NEEDS TOOL

In 2011, the MOH adopted the WHO-designed Workload Indicators for Staffing Needs (WISN) tool as a means for effective and efficient health workforce planning and management. ZISSP provided technical and financial support to initiate implementation of the WISN project, including funding orientation workshops for the WISN technical committee and expert working group. ZISSP also funded pilot data collection and analysis exercises for selected health facilities, namely Kalingalinga, Chawama, Chilenje and UTH, to provide information on how best to roll out implementing use of the tool countrywide. Once established, the WISN tool will assist the MOH to determine staffing needs based on the workload in health facilities.

2.2 FAMILY PLANNING AND ADOLESCENT REPRODUCTIVE HEALTH

2.2.1 TRAINING OF HEALTH CARE WORKERS AND TUTORS IN LONG TERM FAMILY PLANNING

ZISSP supported the MOH in training 37 health care workers from Northern and Western Provinces in long-term family planning (LTFP) methods: 21 were male and 16 were female. ZISSP provided on site

supervision to 15 health care workers from the Northern Province two months after they received their training. Prior to training in each province, ZISSP conducted site assessments to determine their suitability to provide LTFP methods and since most health facilities in the province did not have skilled health providers to provide LTFP, training healthcare workers was necessary.

In order to strengthen the FP pre-service education component, ZISSP supported training of 28 nurse tutors and clinical instructors in LTFP. These trained staff then taught pre-service student nurses and midwives, increasing the knowledge and skills of pre-service student nurses and midwives who in turn will provide a wide range of FP services in both urban and rural areas when they complete their training.

The Family Planning Specialist and two provincial trainers conducted the post-training follow up of nurse tutors in four districts (Ndola, Kitwe, Mufulira and Chingola) covering seven schools (Kitwe School of Nursing and Midwifery, Ndola School of Nursing and Midwifery, Mufulira School of Nursing and Midwifery and Chingola Direct Entry Midwifery). The team interviewed the trained tutors and clinical instructors to determine the retention of the knowledge and skills. The team also interviewed the in-charges of the schools to solicit support for the implementation of the FP program in the schools and to identify any challenges. Schools still require essential basic equipment, pelvic models and training arms for demonstrations during LTFP trainings.

2.2.2 COMMUNITY - BASED DISTRIBUTORS OF FAMILY PLANNING TRAINING MATERIALS

In 2011, the MOH and its partners identified the need to review existing community- based distribution (CBD) training materials and to develop comprehensive national training manuals aimed at standardizing and ensuring quality community-based FP service provision. ZISSP in collaboration with the MOH and other cooperating partners reviewed and finalized the CBD training materials, which will be used for training of CBDs in the 27 target districts in 2012 to help expand access of FP services to address the unmet need.

2.2.3 DEVELOPMENT OF ADOLESCENT HEALTH STRATEGY

ZISSP provided technical and financial support in developing the adolescent health (ADH) strategy through a consultative process. ZISSP hired a consultant who worked with stakeholders to review the findings from the situation analysis conducted in 2009 - 2010 and incorporated these into the strategy. The consultant has initiated the costing of implementing the ADH strategy which will be completed in early 2012.

2.2.4 DEVELOPMENT OF NATIONAL STANDARDS FOR DELIVERY OF ADOLESCENT FRIENDLY HEALTH SERVICES

As a follow up to the development of the ADH strategy, ZISSP supported the MOH to develop adolescent health standards. The national standards will serve as a guide to all organizations providing health services to adolescents and youths. As a companion to the ADH strategy, a communication strategy is required. ZISSP developed a concept note for developing the ADH communication strategy. The communication strategy will be fully developed in conjunction with the MOH and adolescent health partners.

2.3 EMERGENCY OBESTETRIC AND NEONATAL CARE

2.3.1 TRAINING OF HEALTH CARE WORKERS IN EMERGENCY OBSTETRIC AND NEONATAL CARE

ZISSP identified 148 potential emergency obstetric and neonatal care (EmONC) sites in the 27 target districts. Subsequently, the project developed a plan to train the health care workers from these sites, which included the number of health care providers to be trained per district and set the training schedule and post-training follow-up for the period 2011 - 2014. ZISSP undertook an exercise to select two new training sites. Kitwe Central and Chipata General Hospitals joined the existing EmONC training sites of University Teaching Hospital and Ndola Central Hospital. ZISSP provided technical support to ensure that the new EmONC training sites were prepared to offer EmONC practical trainings to health workers and handed over new EmONC training materials to the two training sites. ZISSP in collaboration with the MOH also identified local EmONC coordinators for each training site. The project also reviewed the training materials and equipment at each site and developed a list of training requirements required for each site.

ZISSP identified and trained 22 health care workers from six provinces (all except Northern, North-Western and Western Provinces) to be new national EmONC trainers in order to ensure that adequate trainers were available to implement the EmONC training plan. These trainers were drawn from level one (5 trainers), level two (7 trainers), and level three (10 trainers) health facilities.

With the above-mentioned foundation laid, ZISSP worked with MOH to train 135 health care workers and nurse tutors (59 females and 76 males) in the third and fourth quarters of 2011. The health care workers were drawn from 25 districts, 13 of which were ZISSP target districts in 5 provinces. The total number of health care workers trained in 2011 exceeded the target of 80 for the year because ZISSP took the opportunities presented to leverage resources with other partners and also responded favorably to the urgent need to train health workers in one of the four districts implementing the "Saving Mothers Giving Life" endeavor.

Overall, the trainings succeeded in providing the health care providers with the necessary skills and knowledge to manage obstetric emergencies. However, during one training for Southern Province, only 60% of participants obtained a pass mark of 70% or more. The project needs to consider providing additional post-training on-site mentorship for participants who did not meet the pass mark so that they can improve their EmONC skills and knowledge.

2.3.2 SITE AND EQUIPMENT ASSESSMENT

Prior to each training, ZISSP supported site and equipment assessments to prepare the sites to provide EmONC. Challenges identified during these exercises included inadequate equipment for optimal provision of EmONC services particularly at health center level, lack of mothers' waiting shelters, poor staffing levels, lack of emergency transport, and long distances between basic EmONC and comprehensive EmONC facilities.

2.3.3 REVIEW OF THE EMERGENCY OBSTETRIC AND NEONATAL CARE TRAINING PROGRAM

ZISSP funded a meeting to review the EmONC training program in Zambia and made recommendations to strengthen training and practice. The meeting provided an opportunity to orient national EmONC trainers and members of the Technical Working Groups (TWG) to the elements and processes of clinical mentorship. Key recommendations from the meeting included:

- There is need to separate basic and comprehensive EmONC training.
- Each training site needs to be provided with an LCD projector and printer.
- All training sites need to procure more models.
- The provinces and districts need to be more involved in conducting site assessments, selecting participants, and participating in EmONC mentorship.

2.3.4 COMMUNITY MOBILIZATION FOR BETTER MATERNAL AND NEONATAL OUTCOMES

In order to prepare families and communities to access facility delivery for normal, emergency maternal and newborn care, ZISSP worked with American College of Nurse-Midwives (ACNM) and the MOH to begin adapting the Home-Based Life Saving Skills (HBLSS) teaching tools to the Zambian context and introduce it in communities nationwide. HBLSS is a proven community program that helps pregnant women, families, and their caregivers to recognize a pregnancy complication, know what to do when they see this, and take life-saving actions while transporting the woman or newborn to a health facility. HBLSS teaching tools will support the Safe Motherhood Action Groups (SMAGs) to share knowledge more systematically with community members.

Discussions were held between ZISSP and MOH which concluded that the SMAGs were the best vehicle for implementing this concept. In order to provide the visiting consultant with a better understanding of how community groups manage safe motherhood interventions, ZISSP supported a community assessment in six rural health facilities and their surrounding communities in Masaiti District.

2.3.5 ASSESSMENT OF THE DIRECT ENTRY MIDWIFERY SKILLS

ZISSP undertook an assessment of the skills laboratories at the three Direct Entry Midwifery (DEM) schools and developed a list of equipment that was required for these schools. ZISSP through its sub-contractor ACNM purchased the required equipment. This was followed by training of the nurse tutors and clinical instructors on the use of models and equipment for the skills laboratories.

2.3.6 EVALUATION OF THE DIRECT ENTRY MIDWIFERY PROGRAM

ZISSP in collaboration with the MOH and the Clinton Health Access Initiative conducted an evaluation of the DEM program to determine the capabilities of the certified midwives following the completion of their two year training with an additional one year work experience. The evaluation results will be released in early 2012 and will be used to institute corrective measures to the training program if any

are required, and further provide an evidence-based perspective to support implementation of the DEM program.

2.4 CHILD HEALTH

2.4.1 INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES

In 2011, ZISSP provided technical and financial support to train 123 health care workers in integrated management of childhood illness (IMCI). These were from 5 districts (Luangwa, Chongwe, Mambwe, Nyimba, Lundazi, Mkushi) across 3 provinces (Lusaka, Central and Eastern). ZISSP also provided support for a post-training initial follow-up visit for 96 of the participants. One of the visits to Chongwe District revealed that the potential number of health workers to be trained in IMCI was three times the initial estimation in order to reach saturation levels of 80%. The increased number of health workers was due to new recruitment, and staff transfers leading to difficulties in attainment of the recommended saturation level. To address this, in 2012, ZISSP will work with the provincial and district Clinical Care Teams to introduce an IMCI mentorship program at the district level. During the same post-training assessment, it was noted that the inclusion of a pharmacy technologist as a participant in a facility IMCI training led to a good practice of the re-enforcement of rational use of drugs and provision of supplemental recommended IMCI drugs to health facilities.

ZISSP also provided technical and financial assistance for reviewing and adapting the facility IMCI training materials to support the computerized training course (ICATT).

2.4.2 EXTENDED PROGRAM FOR IMMUNIZATION

ZISSP supported the MOH to conduct a situation analysis to document progress on the Reach Every Child in Every District (RED) strategy implementation and to identify gaps to be strengthened for effective implementation. This was done in 13 districts from 7 provinces with poor vaccination coverage. The districts include Kabwe, Chibombo, Chipata, Chadiza, Kawambwa, Nchelenge, Chongwe, Luangwa, Nakonde, Mpika, Sesheke, Choma and Kalomo.

The assessment provided clear information to strengthen the RED training manual, as well as the planning and monitoring tools for immunization services. The evaluation also showed that less than a third (29%) of the districts staff was trained on immunization in the last 3 years. The findings further showed that there was no standardized duration of training in the RED strategy for health staff and community volunteers. Following this assessment, ZISSP provided technical assistance to conduct the review and update of the RED strategy training package as well as refine the Extended Program for Immunization (EPI) integrated supervisory tool. Using the revised training package, ZISSP, in collaboration with the WHO, trained 225 health staff in the RED Strategy implementation in three provinces, namely Lusaka, Luapula, and Copperbelt.

2.4.3 STRENGTHENING NUTRITION INTERVENTIONS AND LINKAGES

ZISSP trained 15 nutritionists (9 province and 6 district-based officers) on the Essential Nutrition Package. Some of these nutritionists were new appointees, while others were to be elevated from the

district level to the position of provincial nutritionist. ZISSP will continue to provide on-site mentorship to strengthen their capacity in nutrition interventions.

ZISSP in collaboration with other stakeholders provided technical and financial support to the National Food and Nutrition Commission (NFNC) to host the Food and Nutrition Consultative Forum. The meeting identified strengthening of private partnerships and sector coordination as key steps to the successful implementation of nutrition interventions. The meeting also provided a platform for initiating the development of guidelines for Scaling Up Nutrition (SUN) interventions. Following this forum ZISSP provided support to NFNC to host two sector coordination meetings, which refined the inter-sectorial strategic plan and devised a way forward on the SUN.

In August 2011, ZISSP provided technical and financial support to the MOH and the NFNC to launch the World Breastfeeding Week in Kabwe District. Hundreds of men, women and children converged at Makululu grounds on 4th August 2011 to commemorate World Breast Feeding Week. In addition, ZISSP funded the training of 101 private sector health workers drawn from Lusaka, Kabwe, Kitwe, Livingstone, and Ndola in infant and young child feeding. The aim of this training was to standardize private and public information on IYCF.

2.4.4 TRAINING OF HEALTH WORKERS AND COMMUNITY VOLUNTEERS IN INFANT AND YOUNG CHILD FEEDING

With the assistance of a short-term nutrition consultant, ZISSP developed an ambitious plan to train 72 health care workers and 150 community members in infant and young child feeding (IYCF) and community-based growth monitoring and promotion (CBGMP) within a three-month period. ZISSP trained 73 health care workers from three districts (Mwinilunga, Mbala, and Masaiti) in IYCF. Pre- and post-test results indicate that knowledge and skills acquisition took place. In Mbala, the pre-test assessment scores ranged from 24 – 63% with an average of 48.4% and the post-test results ranged from 57 – 93% with an average of 75.7%. The training of community members was equally successful; 150 community members completed a combination of community IYCF and CB GMP. Community members were drawn from six districts, Solwezi, Mwinilunga, Ikelenge, Mbala, Mpika and Masaiti.

ZISSP funded a meeting to develop nutrition mentorship checklists to be utilized during post training mentorship of health care workers and community members. These tools were piloted during mentorship of health care workers and community members in four districts (Mwinilunga, Solwezi, Mpika and Mbala) and the findings will be used for finalization of the tools in 2012.

3. TASK TWO: SUPPORT TO THE PROVINCES AND DISTRICTS

3.1 QUALITY IMPROVEMENT AND CLINICAL CARE

3.1.1 DEVELOPMENT OF QUALITY IMPROVEMENT OPERATIONAL GUIDELINES AND REVIEW OF THE TRAINING PACKAGE

Over the years, efforts have been made to implement quality improvement (QI) in health service delivery in Zambia through a Performance Improvement Approach (PIA) strategy. However, a number of challenges have hindered institutionalization of QI, in particular, the lack of operational guidelines, the extremely limited number of four national trainers based in Lusaka for both the public and private sectors, and the differing QI approaches and training packages used by various cooperating partners for specific programs targeting the same health workers.

The MOH established a QI unit under the Directorate of Clinical Care and Diagnostics in the first quarter of 2011. As a result, ZISSP facilitated establishing a QI TWG in collaboration with the MOH. Through the TWG, ZISSP was able to address two major issues affecting QI, namely the lack of national QI operational guidelines and the need to review the QI training package to ensure its quality and relevance. ZISSP supported a series of workshops and provided technical assistance (TA) to develop the QI operational guidelines.

To build upon the draft QI guidelines, ZISSP supported the review of the in-service QI training package to align it with the draft QI operational guidelines. The revised QI in-service training package now incorporates the existing QI strategies, i.e., Performance Assessment (PA), and has harmonized them with PIA to ensure that QI becomes institutionalized in all existing health programs. This is in an effort to link and integrate all MOH systems that can support better quality services.

3.1.2 SENSITIZATION OF THE MINISTRY OF HEALTH POLICY AND PROGRAM MANAGERS TO QUALITY IMPROVEMENT

After developing the draft QI national guideline and revision of the in-service QI training curriculum, the QI TWG sensitized policy makers and managers to the importance of institutionalizing QI in all programs at all levels to realize the MOH vision "to provide equity of access to cost effective quality health care to all Zambians as close to the family as possible." ZISSP fully participated in the preparation and facilitation of a two half day workshop for policy makers and program managers. The workshop participants valued this orientation as demonstrated through pledging their support for the program. The next step is to engage a mix of program officers in implementing QI activities.

3.1.3 FIRST NATIONAL QUALITY IMPROVEMENT CONFERENCE

As a follow up to the sensitization of policy makers, the QI TWG planned the first national QI conference, "Better Health Outcomes through Quality Improvement," jointly funded by ZISSP,

Elizabeth Glazer Pediatric AIDS Foundation (EGPAF), and AIDS Relief and was held in quarter four of 2011. The objectives were:

- To provide leadership and ensure a formal strategy of quality assessment and improvement in health care service delivery.
- To demonstrate the importance of data to guide decisions that will improve quality of health care.
- To enable participants to share quality improvement best practices.

ZISSP actively participated in preparing the national QI conference and made a presentation to highlight USAID's support to the MOH in strengthening systems for QI. This conference coincided with the Africa Regional QI Conference held in Kampala, Uganda. ZISSP sponsored one QI national trainer from Central Province and the ZISSP Quality Improvement and Clinical Care Team Leader to attend. The theme was "Catalyzing and Institutionalizing Quality Improvement". Relevant lessons learned from other countries which participated in this conference were identified and incorporated into the Zambia MOH draft national QI guidelines and in-service training package.

3.1.4 REVIEW OF THE CLINICAL MENTORING CURRICULUM AND OPERATIONAL GUIDELINES

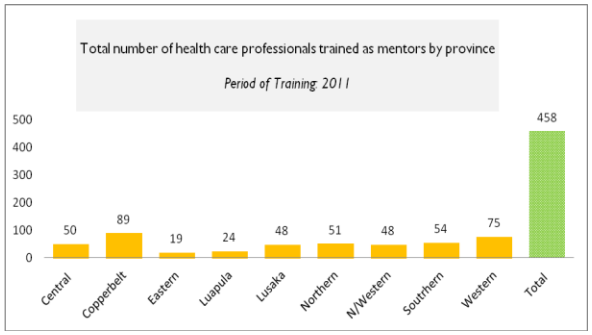
Implementation of formal clinical mentoring in the health sector in Zambia began in 2008 and initially targeted health workers in HIV-related programs. The MOH has prioritized mentoring of health care providers as a way to improve adherence to clinical care standards and improve the quality of health care. In particular, the MOH identified the need to mentor primary health care workers because they rarely had anyone to consult when faced with difficult and challenging health conditions.

In an effort to integrate all relevant program areas and harmonize clinical mentorship tools, ZISSP collaborated with the MOH to support the review of the national clinical care mentoring guidelines and develop a new clinical mentoring training curriculum which is suitable for all health services and programs. Mentoring tools have now been developed in the areas of surgery, internal medicine, pediatrics, IMCI, EmONC, pharmacy, laboratory, nursing care, family planning, focused ante natal care (FANC), intrapartum care, postnatal care, and adolescent reproductive health care. The tools are undergoing final editing and formatting before bulk printing and distribution.

3.1.5 TRAINING OF TRAINERS FOR CLINICAL MENTORING

ZISSP collaborated with the MOH to pilot the revised mentoring training curriculum by training of 27 provincial trainers from nine provinces. These trainers are expected to train multi-disciplinary clinical care mentoring teams at provincial and district levels. Figure 3.1 shows the number of multi-disciplinary mentors trained in 2011. A total of 458 mentors have been trained through 19 training programs in the nine provinces in the country.

FIGURE 3.1: NUMBER OF MULTI- DISCIPLINARY MENTORS TRAINED IN 2011



3.1.6 ESTABLISHMENT OF MULTI – DISCIPLINARY CLINICAL CARE TEAMS FOR CLINICAL MENTORSHIP

The MOH is now implementing an integrated mentoring program aimed at improving the overall quality of health services. CCTs, which were initially established and trained during the Health Services and Systems Program (HSSP) but are now fully "owned" by the MOH, are multi-disciplinary teams based at provincial and district levels with a mix of competencies necessary for quality patient care. CCTs are mandated to run the QI process with a focus on patient case management at all levels of the health care system. The CCTs provide a critical function to ensure an integrated and comprehensive approach to not only cover mentorship in clinical case management, but to also strengthen systems such as pharmaceutical logistical management, nursing care, diagnostic services and health information management.

At PHO level, program officers form a multi-disciplinary CCT that is responsible for coordinating, monitoring and evaluating the mentoring program in the districts and health institutions in the province. The provincial level team also provides technical assistance to build the capacity of the CCTs at lower levels, helping to increase lower level providers' access to mentors for clinical consultations as and when needed. Building clinical care teams based in the district or provincial health offices promotes the sustainability of the mentorship program because the systems and capacity for mentoring rest within the MOH at the health service implementation level rather than in the team of an external implementing partner. This process allows MOH to recognize skilled and talented clinicians and technicians by selecting them as mentors. In addition the mentors are closer to the providers who require mentoring, therefore mentoring can be more frequent and mentors are accessible for consultation.

In 2011, the ZISSP clinical care specialists (CCS) supported PHOs to establish multi-disciplinary CCTs in eight provinces and 68 districts. The multi-disciplinary CCTs include clinicians, nurses, health information officers, pharmacy, nutritionists and laboratory personnel. The focus in 2012 will be to build the capacities of the established district CCTs to mentor through technical assistance from the provincial CCTs.

3.1.7 CLINICAL MENTORING OF HEALTH WORKERS

Mentoring health care service providers is the key MOH strategy to transfer relevant knowledge and skills to providers in a cost effective and sustainable manner. ZISSP and the MOH CCSs are implementing mentorship of health workers as a QI strategy. This staff development strategy seeks to transfer skills in the clinical setting, avoiding the need to remove providers from their facility for an off-site training. This also provides an opportunity not only to transfer skills to the health provider, but also to identify and address any barriers on site that may hinder delivery of quality clinical care services.

Although the revision and updating of the clinical mentorship guidelines and the training package are still undergoing finalization by a ZISSP supported consultant, mentors have been trained and mentoring of health workers was initiated to provide feedback to finalize the mentoring curriculum and operational guidelines.

ZISSP CCSs coordinated plans and budgets to support provincial and district CCTs to conduct clinical mentoring in health facilities. By the end of 2011, the provincial and district CCTs with support from ZISSP, conducted 1,083 mentorship sessions in eight out of nine provinces. No mentorship was program

was conducted in North Western Province due to the absence of a ZISSP seconded clinical care specialist to spearhead the activity. A total of 1,001 health workers were mentored (473 females and 528 males) in clinical areas which included clinical case management of ART, TB, male circumcision, malnutrition, malaria, IMCI, antenatal care, intra-partum care (monitoring labor and the use of a partograph), general patient case management (history taking and physical examination of patients,) nursing care, health information management, laboratory quality, and pharmaceutical logistics management.

This is a major accomplishment for the team bearing in mind that mentorship of health workers only commenced in the third quarter of 2011 after completing the review of the national mentorship guidelines and the training package.

TABLE 3.1: NUMBER OF MENTORSHIP SESSIONS AND HEALTH WORKERS MENTORED BY PROVINCE

Province	Number of mentorship session conducted	Number health workers mentored
Central	77	72
Copperbelt	63	63
Eastern	64	48
Luapula	24	24
Lusaka	12	12
Northern	64	47
North -Western	0	0
Southern	597	554
Western	182	181
Total	**1,083**	**1,001**

The cumulative total of health worker mentorship sessions as at December 2011 was 1,083 and a total of 1,001 health workers were mentored by the CCTs. Achieving this number was possible towards the end of the year because multi-disciplinary CCTs were established by the PHO with support from the ZISSP CCSs in 68 districts in eight provinces as opposed to the individual CCSs conducting all the mentorship.

Southern Province conducted the highest proportion (58%) of total mentorship sessions to health workers because the province has well-established CCTs from the ZISSP predecessor HSSP that had been implementing this program over a number of years while Northwestern Province did not have a ZISSP seconded CCS to coordinate this activity while Luapula and Eastern Provinces had no CCSs for the last half of 2011.

In 2012, ZISSP will continue to support and facilitate mentoring activities in the districts and will work towards measuring the effect of the mentorship program through the increase in service utilization and the quality of service provision.

3.1.8 SUPPORT TO CLINICAL MEETINGS

The shortage of qualified health workers to attend to patients compromises the quality of clinical case management of patients, especially at primary health care level. Many health workers also lack the

opportunity for consultation on difficult cases. ZISSP through the CCS used clinical meetings as a complementary strategy to provide continuous professional staff development to improve the quality of clinical case management.

Clinical meetings occur in facilities and provide a forum for updating health workers on case management protocols by presenting educative and challenging but interesting case studies. Clinical meetings are also used as a forum for presentation and discussion of maternal death, still births, neonatal/infant/under 5 and general in-patient mortality aimed at improving future patient case management. The CCSs through the CCTs at PHO and District Health Office (DHO) levels coordinated and facilitated 247 clinical meetings in seven provinces against a set target of 200 clinical meetings.

Participants talk with a patient during a clinical mentoring practical training session in Kabwe, Central

3.1.9 PARTICIPATION IN PERFORMANCE ASSESSMENT AND TECHNICAL SUPPORT SUPERVISION

Performance Assessment and Technical Support Supervision (PA/TSS) are also important MOH quality improvement strategies. Each activity occurs twice a year. One of the major objectives of PA is to establish the gaps in health service provision. This is done through monitoring the performance of health institutions against agreed objectives and indicators. TSS seeks to address the gaps.

The findings of the PA provide information on the areas where ZISSP CCSs and their MOH counterparts at PHO and DHO can provide technical assistance and strengthen the institutional systems to improve service delivery.

Provinces and districts face challenges to conduct focused and effective PAs because some program officers do not clearly understand the relevance of PA as a QI strategy and do not adequately prepare for the exercise. PA teams review the previous performance assessments, Health Management Information System (HMIS) data, clinical mentorship and technical support supervision reports in order to prepare for the PA. Districts and provinces often omit the preparation step in the PA process.

One of ZISSP's important achievements has been to strengthen pre-PA meetings before conducting the actual PA to review the previous PA and TSS findings and the HMIS data. This analysis lays the groundwork for the most recent round of PA. During the year, all the CCSs supported and facilitated the PA process. The CCSs for Western, Southern and Central Provinces went further and facilitated the PA preparatory meetings to review various reports and develop the PA implementation plan.

Pre-PA meetings are aimed at monitoring previously identified gaps in clinical case management at a given health facility. The meeting participants review the technical support supervision that was provided and check current performance as a follow up on solutions offered previously. Post PA meetings on the

other hand aim at analyzing the performance gaps from the PA reports and identifying appropriate technical support supervision strategies that are cost effective such as clinical mentoring and clinical meetings. In the year 2012, the ZISSP CCSs will conduct bi-annual PA and TSS visits to districts and hospitals.

3.1.10 PROVINCIAL QUARTERLY PROGRAM PERFORMANCE REVIEW

The HMIS has been in place for many years and the MOH has trained health workers to use the system. As a result of a recent organizational restructuring, some newly recruited program officers have not yet been oriented to HMIS. This makes it difficult for new staff members at PHO, DHO and health facilities to use HMIS indicators to monitor health program performance.

The CCSs conducted provincial quarterly inter-district and institutional self and peer assessment in selected health program indicators reported through HMIS as a means of strengthening the monitoring and evaluation of health programs to ensure QI. The objective is to build the capacity of facility-level health workers to analyze their own information for planning and management purposes. Better planning and management would ultimately contribute to improved quality of service delivery and utilization of health services.

The provincial CCTs expect that the district managers will use their new skills to build the capacity of health facility staff by introducing the HMIS indicators to District Integrated Meetings. This forum allows district managers to review health programs, discuss the achievements, challenges, and share effective practices.

During the year 2011, Luapula and Eastern Provinces conducted review meetings in the third quarter to which provincial teams from Lusaka and Copperbelt (five and three persons respectively) were invited to learn, understand the process, share experiences and provide feedback as peer reviewers. This helped build their technical capacity in conducting program performance reviews with districts in their provinces. Western and Copperbelt Provinces held similar program performance review meetings with technical and financial support from ZISSP in the fourth quarter. Managers and program officers from all the districts, level 2 hospitals and cooperating partners in the provinces attended the meetings.

The participants in these meetings discussed health performance indicators in comparison to set standards and targets in HIV/AIDS (counseling and testing, ART, PMTCT, Early Infant Diagnosis), TB, malaria, maternal and child health (EPI and nutrition) and human resource programs. The meeting in Western Province also discussed the funding situation, and epidemic surveillance and preparedness in the province.

ZISSP plans to support provincial quarterly performance review meetings in all the nine provinces in the year 2012 as a strategy for quality improvement in data management.

3.1.11 REVIEW OF PERFORMANCE ASSESSMENT TOOLS

During the third quarter of 2011, the MOH initiated the review process of the PA tools in order to make the exercise more effective and improve its value for QI. The ZISSP CCSs participated in the review at the provincial level while the QI and CCS team leader collaborated with colleagues at the MOH and submitted inputs to some health service and program indicators in ART and PMTCT. CCSs will participate in the follow on process to finalize the revision of the tools as planned by MOH in 2012.

3.1.12 PARTICIPATION IN THE 2012 – 2014 MINISTRY OF HEALTH PLANNING CYCLE

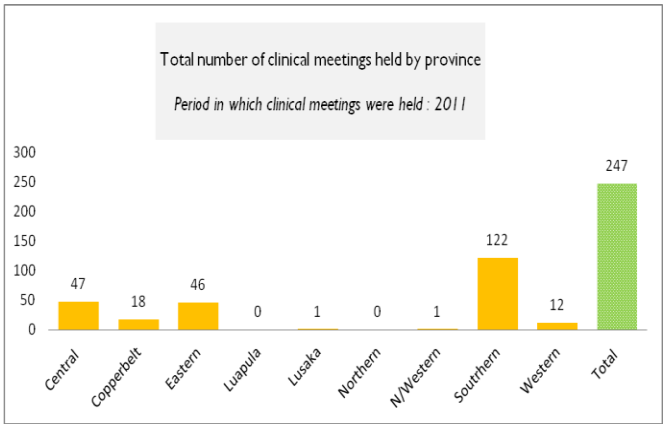
The MOH provides technical guidance to the annual planning process to ensure evidence-based planning for health programs. This process begins with identification of focus areas in all health programs each year based on performance indicators from the preceding year. This is followed by identifying and selecting proven cost-effective interventions which are given as technical updates during the national annual launch to the PHOs at which all the CCSs were present for the 2012-2014 Mid Term Expenditure Framework (MTEF) planning cycle.

Prior to dissemination of the technical updates to the districts and health institution managers in their provinces, the CCSs adapted the national technical updates to suit their respective provincial situations. The CCSs attended and facilitated the launch in the districts to ensure that the focus areas are adapted to the district situation analysis. The CCSs further provided follow up technical assistance as the districts and their health facilities worked on their plans. During this exercise, some districts had difficulties analyzing their performance from the preceding three years. The lack of performance data undermined the district's ability to evaluate trends that help to identify planning priorities for the next three years. Some districts had incomplete data that hindered thorough analysis. In other districts, newly recruited health information officers were not yet conversant with the HMIS. In the latter case, the CCSs assisted with the relevant analyses. The CCSs worked to ensure that the districts and health facilities included priority health problems in their 2012-2014 work plans.

In the year 2012, the ZISSP CCSs, working in synergy with the Management Specialists (MSs) and Community Health Coordinators (CHCs), will support and participate in the MOH 2013-2015 planning cycle at provincial and district levels.

Southern Province through coordination of the CCTs by the CCS reported the highest number of clinical meetings. Inadequate planning and or coordination of activities resulted in either only one or no clinical meetings being conducted in some of the provinces, for example in Luapula and Northern Provinces. In 2012, the ZISSP CCSs will ensure that more facilities conduct regular clinical meetings. During some of these clinical meetings ZISSP CCSs provided health workers with updates on malaria, prevention-of-mother-to-child transmission of HIV (PMTCT) and ART guidelines.

FIGURE 3.2: NUMBER OF CLINICAL MEETINGS COORDINATED AND FACILITATED BY PROVINCE IN 2011



3.2 MANAGEMENT AND LEADERSHIP

3.2.1 STRENGTHENING CAPACITY OF PROVINCIAL AND DISTRICT LEVEL STAFF IN PROGRAM PLANNING AND BUDGETING

The MOH recruited new planning officers in the PHOs and DHOs. Most of these planners are straight from the universities and lack capacity to facilitate health planning according to the MOH planning guidelines. A gap analysis conducted by ZISSP in October 2010 revealed that for the 2011 health planning cycle to be effective, all new planners needed exposure to the MOH planning guidelines and approaches (Marginal Budgeting for Bottlenecks and Logical Framework). In order to create a pool of trained MOH planners who would in turn train other district staff, ZISSP worked in collaboration with the MOH to train 90 planning officers and program managers (71 males and 19 females), establishing a system for training new planners deployed to provinces and districts.

3.2.2 STRENGTHENING PARTNER COLLABORATION AT PROVINCIAL AND DISTRICT LEVEL

Many stakeholders commented that ZISSP's efforts to organize partner collaboration meetings in provinces and districts are useful and beneficial. During the past year, ZISSP provided technical and financial support to the nine provinces and 27 target districts for conducting these meetings. The meetings provide a platform for partners to share information on program implementation and achievements and to identify areas that require joint efforts. There were few opportunities for such discussions prior to ZISSP's intervention.

The meetings continue to show positive outcomes. For example, in the Southern Province one meeting revealed that only one of the six laboratories in Kalomo and Kazungula assessed by the JICA Scaling –up of Quality HIV and AIDS Care Services Management (SHIMA) project consistently provided quality and reliable laboratory results. As a result, the SHIMA project conducted trainings for laboratory personnel and assisted with equipment maintenance in all six districts. When the partner meetings occurred at the same time as the provincial and district planning meetings, the partners not only participated in the planning process, but they also pledged support for some of the priority health interventions activities which did not have adequate funding in the 2012 Action Plans.

In Eastern, North Western and Western Provinces, the cooperating partners meetings led to the formation of Stakeholder Steering Committees. During 2012, efforts will continue to engage other partners to assist in establishing Stakeholder Steering Committees in provinces and districts where these have not yet been formed. These committees can facilitate maximizing partner financial support to health programs and strengthen partner collaboration in planning, implementation and monitoring and evaluation of health services.

3.2.3 TECHNICAL SUPPORT TO MINISTRY OF HEALTH HEADQUARTERS, PROVINCES, DISTRICTS AND HOSPITALS FOR ANNUAL PLANNING

Although institutions go through the planning process annually, they continue to face challenges in developing acceptable plans. Program officers often fail to use existing information to guide decisions and set priorities. Planning staff also sometimes lack sufficient skills to use new planning concepts such as activity-based budgeting, logical frameworks, cost frameworks, and bottleneck analysis. During 2011,

ZISSP provided technical support to the MOH for the annual planning process in the areas described below.

3.2.4 DEVELOPING AND BUILDING CONSENSUS ON PLANNING TOOLS AT THE PROVINCIAL HEALTH OFFICE LEVEL

ZISSP worked with the MOH to revise the planning handbooks. This revision focused on provincial level planning, a topic not previously addressed. The revised handbooks are now aligned with the new MOH planning procedures and will be used by both the PHOs and central MOH to develop their action plans. The team also revised the handbook for statutory boards, to align it with the new planning requirements, and the handbook for health centers, health posts and community level to incorporate guidance on how to engage communities in planning. The revision is finalized, and the planning handbooks will be printed during the first quarter of 2012. This process completes the standardization of the MOH planning process at all levels, including the community involvement in planning at health center level.

3.2.5 PARTICIPATION IN THE MINISTRY OF HEALTH NATIONAL AND PROVINCIAL PLANNING CYCLE

ZISSP's mandate is to work within the MOH structure to strengthen the health system. To achieve this, ZISSP participated in the MOH pre-launch meetings to identify priority focus areas for the 2012-2014 MTEF planning cycle. This enabled ZISSP staff to identify the MOH priority areas and ensure that the Program's priority activities are in line with the MOH priority areas.

To strengthen planning at provincial level, ZISSP collaborated with the MOH-Headquarter to orient PHO staff on how to use the new provincial planning to better assist health institutions under their jurisdiction in providing health services.

3.2.6 PARTICIPATION IN DISTRICT PLANNING CYCLE

Districts remain the vehicle for delivery of the MOH focus health interventions. To strengthen planning at this level as well as in other health institutions, ZISSP collaborated with PHOs in all the nine provinces to provide onsite coaching for planning to districts, and to provincial and district hospitals. The coaching focused particularly on using data, priority setting, identifying high impact health interventions to address identified health problems, and assisting program officers to work through the various planning processes.

ZISSP specialists worked with the provincial teams to conduct technical reviews and finalize action plans of individual health institutions. A technical review is a process of going through an action plan to check its completeness in terms of addressing the identified health priorities guided by the available data from the HMIS and other data sources, the costing of activities and the distribution of funds across the different program areas.

> *"These meetings are helpful. Many times we as a district health team have been misunderstood by many stakeholders… we really have had no forum to share our own challenges with them"*
> – Planner- Lukulu District

ZISSP support in all provinces helped to expedite the completion and submission of 2012-2014 health plans to the MOH for budget consideration.

3.2.7 STRENGTHENING MANAGEMENT AND USE OF DATA

Data management and use remain major challenges for program officers in provinces, districts and hospitals. ZISSP continued to support PHOs and DHOs analyzing their data to prepare for performance assessments and for the planning process. ZISSP supported provincial integrated meetings (PIMs) and district integrated meetings (DIMs) that give PHOs and DHOs the opportunity to review their performance on key health indicators such as maternal and child health, malaria, HIV/AIDS, nutrition and outpatient attendance. The review meetings seek to identify and resolve program challenges at district or province level and contribute to data quality improvement.

These meetings revealed problems with data analysis and interpretation by program officers especially at health center levels where immunization coverage was discussed and reported to range from 150%-370% for fully immunized children. In other districts, data incompleteness and consistencies were observed between the point of collection (health center) and aggregation (district level). This situation tends to affect the district's performance. To address the challenges with data quality, ZISSP provided financial and technical support to PHOs through their Senior Health Information Officers who trained program officers in data quality audits in eight of the nine provinces. So far 255 (168 males and 87 females) program officers received this training during 2011. Trainers observed that the program officers participating in the training had not understood or appreciated their role in data management because they thought the responsibility belonged to the Senior Health Information Officer and/or the monitoring and evaluation staff. In addition, because program officers lacked training for data management, they also lacked the skills to verify, validate, analyze and interpret data to assess program performance. During 2012, ZISSP will monitor improvements in data management and use for decision making by program officers at district/hospital levels through conducting quarterly reviews of revised district action plans to check whether the revisions are consistent with district performance for the quarter.

3.2.8 REVISION OF PERFORMANCE ASSESSMENT TOOLS

PA is a systematic process in which MOH managers use established tools to review the performance of institutions in relation to an accepted set of standards in relation to the NHSP. With changes in the NHSP priorities, the MOH decided to revise the PA tools to address these priorities and make them more action-oriented.

ZISSP supported the MOH in the revision process by consulting with key stakeholders from the central MOH, PHOs, DHOs, in addition to hospital, training institution, and health center levels. The first phase involving the MOH-central level is complete. The next step will draw comments from the provinces, districts, hospitals, training institutions and health centers. MOH will then share the revised tools with a wider audience to build consensus before completing the revisions. In 2012, ZISSP will support the consensus meeting with stakeholders and hire a consultant on behalf of MOH to edit the revised tools, making them ready for use by relevant institutions.

3.2.9 DEVELOPMENT OF RESOURCE MAPPING TOOL

The National Health Accounts (NHA) is an internationally recognized framework that measures and tracks the use of total public, private (including household), and donor health care expenditures in a country. However, Zambia has mobilized resources from several partners including ZISSP to conduct their fifth round of the NHA survey. This has been necessitated by a number of developments within the health sector such as the withholding of funding by key donors to the sector, the new National health strategic Plan which need to be costed and need to institutionalize the NHA.

As the initial step to support the MOH to institutionalize the NHA, ZISSP collaborated with the MOH to develop a resource mapping template that will support tracking of partner resources and activities at provincial and district levels to ensure continued tracking of health care expenditure from various partners. Twenty-seven provincial staff (planners, accountants and MSs) have been oriented to the tool with ZISSP financial and technical support. This tool will be piloted during the NHA survey scheduled for February 2012. It is expected that the tool will thereafter be used by MOH to track partner resources on a bi-annual basis as a first step towards institutionalization of the NHA system. During 2012, ZISSP plans to develop a database for the resource reports.

3.2.10 DEVELOPMENT OF A RESOURCE ALLOCATION FORMULA

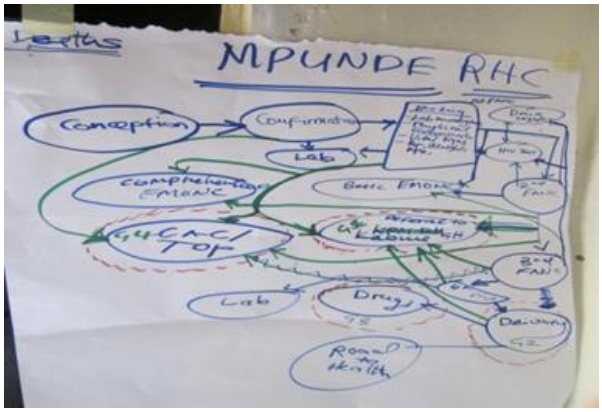
Resource allocation to levels 2 and 3 hospitals in Zambia has been the basis of historical budgeting and allocations. Regions and provinces that were well-endowed with health care facilities at these levels received a disproportionately high amount of resources, perpetuating inequitable and inappropriate allocations of resources to levels 2 and 3 hospitals. To ensure more equitable resource allocations, ZISSP collaborated with the MOH and the University of Zambia (UNZA) Economics Department to develop a resource allocation formula for level 2 and 3 hospitals. This tool has been developed and shared with clinicians who have provided their input. Finalization and editing of the tool will be completed in January 2012 after which, the tool will be handed over to MOH for use during the 2012 planning cycle. ZISSP's role will be to monitor implementation of the tool.

3.2.11 TRAINING OF TRAINERS AND MENTORS FOR THE MANAGEMENT AND LEADERSHIP ACADEMY

One of ZISSP's key activities in the management domain is to strengthen management and leadership skills of provincial, district and hospital level managers through short courses to build leadership and management skills. During the first half of 2011, ZISSP and its subcontractor BRITE worked with the MOH to adapt the Management and Leadership Academy (MLA) curriculum to the Zambian context. The adaptation process used a consultative process through holding meetings with MOH central level directors and provincial, district and hospital level managers from all provinces. The purpose was to enable stakeholders to understand the proposed MLA activities; gather opinions regarding relevance of the proposed strategy to the Zambian health sector; share the MLA curriculum previously designed for other countries; and provide an opportunity for stakeholders to include topics that they felt should be added to the curriculum. This consultative meeting received positive feedback from MOH-Headquarters and provincial staff and resulted in the development and refinement of the Zambia Management and Leadership Academy (ZMLA) curriculum.

In September, ZISSP trained the trainers for ZMLA. The 33 participants included 10 trainers from the National Institute for Public Administration (NIPA), three from UNZA, nine PHO managers, and 10

mentors from the ZISSP MS team. The training field tested the curriculum on the trainers and trained the trainers with the adapted curriculum. Participant feedback after the training indicated that the course was very useful and appropriate for the intended level. Since then, 10 training programs have been conducted covering six provinces and four districts with a total number of 251 managers trained: Central MOH- 31, PMO office -72, DHO- 71, hospitals - 50, NGO professionals- 22, and senior chiefs -five.



Model of care for pregnant women at Mpunde health center in Kapiri-Mposhi district of Central Province, red circles represent where deaths mostly occur in the supply chain.

During training participants were given the opportunity to practice what they had learned to consolidate understanding. The first modules covered "Problem Definition" and "Basic Principles of Supply Chain Management". For the first modules, maternal mortality as a priority health problem was used across all cohorts. Participants with guidance from facilitators examined a model of care for a pregnant woman, from first booking to delivery to identify where deaths mostly occurred. Thereafter participants were divided into smaller cohorts of four to five to work on identified problem areas as part of group projects to identify possible causes of deaths. Participants were then expected to suggest an effective model of care for the facility to reduce maternal deaths.

In 2012, ZISSP will provide a second round of trainings using the next set of modules which will cover project/ program management in those provinces and districts that have been trained, and initiate trainings with the first two modules in those that did not yet receive training in 2011.

Mentorship programs will also be initiated for those that have already been trained with a special focus to group projects.

3.2.12 SUPPORT TO THE IMPLEMENTATION OF THE PERFORMANCE MANAGEMENT PACKAGE

The ZISSP MSs provided support to the MOH for the roll out of the MOH PMP in the provinces and districts. The MSs coordinated the PMP training program in the provinces that received financial support from ZISSP, i.e., Northern, Copperbelt, Eastern and Central Provinces, where 216 managers were trained from provinces, districts, and hospitals. These managers will be responsible to roll-out the PMP training to line staff in their respective institutions. The PMP should improve staff motivation and performance by establishing better performance appraisal systems and a regular process to review job expectations and identify the skills that staff needs to perform their roles.

3.3 MALARIA

3.3.1 INDOOR RESIDUAL SPRAYING NEEDS ASSESSMENT

ZISSP provided technical and financial support to undertake a needs assessment in all 72 districts of the country. The purpose was to systematically gather information that would assist the National Malaria Control Program and the indoor residual spraying (IRS) implementing districts to determine their requirements for implementing IRS activities. The data from the assessments were used to forecast requirements for insecticides, personal protective equipment, and other logistical needs.

3.3.2 TRAINING IN INDOOR RESIDUAL SPRAYING

ZISSP trained 105 district-level trainers in IRS techniques, implementation, and supervision. Developing a cadre of trainers for IRS is one of the most important activities of the malaria control program. The aim is to build capacity at national level to ensure that all districts follow national standards.

The trained trainers are responsible for training spray operators before the spray operations commence and also provide technical support supervision to the districts to ensure that the spraying of household structures is conducted in accordance with the IRS guidelines. In the third quarter of 2011, ZISSP provided financial and technical support to 35 districts to train1, 783 spray operators.

The National Malaria Control Center (NMCC) refers to this process as cascade training because the district-level trainers transfer the skills to their local spray operators.

Master Trainer, Francis Matoka, demonstrates how to pressure the pumps during the IRS training of trainer's workshop in June 2011.

3.3.3 SUPERVISION OF INDOOR RESIDUAL SPRAYING ACTIVITIES

During the 2011 IRS spray season, ZISSP worked with the NMCC and the PHOs to supervise and monitor IRS activities in all 72 districts to ensure that the spraying of household structures was conducted in line with the IRS guidelines. At the end of quarter four, two monitoring supervision exercises were undertaken. The major challenge during the 2011 spray season was inadequate funding from MOH for the IRS program. This contributed to late commencement of IRS activities. Some districts started their IRS activities as late as December.

3.3.4 DISTRIBUTION OF IRS INSECTICIDE AND PERSONAL PROTECTIVE EQUIPMENT

ZISSP has the mandate to distribute IRS commodities including insecticides procured by the U.S. Government's President's Malaria Initiative (PMI) which was done through RTI International in 2011. ZISSP supported NMCC in distributing insecticides and personal protective equipment (PPE) to the 35 ZISSP supported districts to ensure that the chemicals reached the districts before the onset of the

rains. All the chemicals received at central level were stored at Medical Stores Limited (MSL) before being distributed to the 35 districts.

3.3.5 INCINERATION OF INSECTICIDE WASTE

ZISSP worked with NMCC to collect and export the DDT waste from the 15 DDT districts for destruction by an approved facility in South Africa. The NMCC obtained a certificate of destruction for all DDT waste. ZISSP led a team of experts including Zambia Environmental Management Agency (ZEMA) and IRS managers to collect the pyrethroid waste (sachets, boxes, and drums) from 54 districts and incinerate them in approved incinerators.

3.3.6 GEOCODING, TRAINING AND ENUMERATIONS

ZISSP trained 20 supervisors and 96 enumerators from five districts to geo-code household enumeration data using personal digital assistants (PDA.) Five districts (Mpulungu, Samfya, Chibombo, Chiengi and Mwense) subsequently completed the geo-coding process and ZISSP supported these districts and NMCC to mine the data from the PDAs and developed a report that was shared with USAID. Strengthening of the National Malaria Control Program by using geographical information system (GIS) mapping tools enables the NMCC to better plan, manage, and report on interventions such as IRS.

3.3.7 ENTOMOLOGICAL INVESTIGATION FOR INSECTICIDE RESISTANCE

In the first quarter of 2011, ZISSP provided technical and financial support for entomological insecticide resistance monitoring in Copperbelt and Eastern Provinces. Results of the resistance monitoring revealed that DDT resistance is widespread in Copperbelt and emerging in Eastern Province. The NMCC presented these findings at a stakeholders' meeting to provide strategic direction which included recommending alternative insecticides in these areas.

Mulenga Musapa, the ZISSP Entomologist, shows some mosquitoes which were caught in Chipulukusu Suburb in Ndola using a CDC light trap.

In the second quarter, ZISSP conducted the second phase of the entomological investigations for carbamates in the districts of Copperbelt, North-Western, and Eastern Provinces. The resistance data from the selected districts showed that anopheles gambiae is resistant to DDT and most of the pyrethroids (Permethrin, Deltamethrin and Lambdacyhalothrin) are susceptible to carbamates and organophosphates.

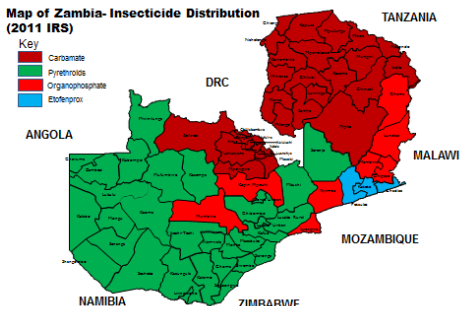
Anopheles funestus was found to be resistant to the same pyrethroids as anopheles gambiae, while it is susceptible to carbamates and organophosphates. Anopheles funestus was also found to be susceptible to DDT in Eastern Province. In July 2011, ZISSP supported NMCC to convene a meeting to formalize

the establishment of the Insecticide Resistance Management Technical Working Group (IRMTWG) whose main responsibility is to coordinate national insecticide resistance management. The IRMTWG held its first insecticide resistance discussion and pesticide selection meeting on July 14, 2011. The members reviewed the insecticide deployment criteria for the 2011 IRS season and developed a map showing the insecticides selected for each district based on the data available on insecticide resistance of malaria vectors.

3.3.8 CREATION OF SIX SENTINEL SITES FOR ENTOMOLOGICAL INVESTIGATION

The IRMTWG agreed that in order for the malaria control program to effectively monitor and manage insecticide resistance, the NMCC should develop a spatio-temporal entomological profile that identifies areas with insecticide resistance and the underlying resistance factors. To do this, ZISSP and NMCC identified six sentinel sites (Kasama, Katete, Kasempa, Kaoma, Kitwe and Luangwa) and started to collect indoor resting vector mosquitoes from these sites and transport them to the central laboratory at the NMCC where they lay eggs. The NMCC team sends the eggs to the University of Liverpool for microarray studies. The microarray data will allow comparison of the genetic structures and gene flow of vector mosquitoes from different selected sentinel sites. These data will establish a baseline for insecticide resistance trends and will support the 2012 plan for insecticide resistance management.

Map of Zambia showing the proposed distribution of insecticides for the 2011 IRS season



3.3.9 TRAINING IN ENTOMOLOGICAL MONITORING

Following the evidence of resistance to the two common insecticides used in the country, there is a greater need to intensify resistance monitoring in all areas where IRS is being implemented. To achieve this, ZISSP trained 54 Environmental Health Technicians (EHT) and IRS coordinators from the 35 districts in entomological monitoring field techniques. Of the 54 trained EHTs and IRS coordinators, 16 were female and 38 were male. EHTs received back packers, aspirators and bioassay bottles and supplies to enable them to function effectively and report data to NMCC that is required for effective decision making.

3.3.10 MAINTENANCE OF THE NATIONAL ENTOMOLOGY LABORATORY AND INSECTARY

In 2011, ZISSP provided substantial technical and logistical support to maintain a breeding mosquito colony at the NMCC for entomological monitoring, including paying monthly wages for two insectary

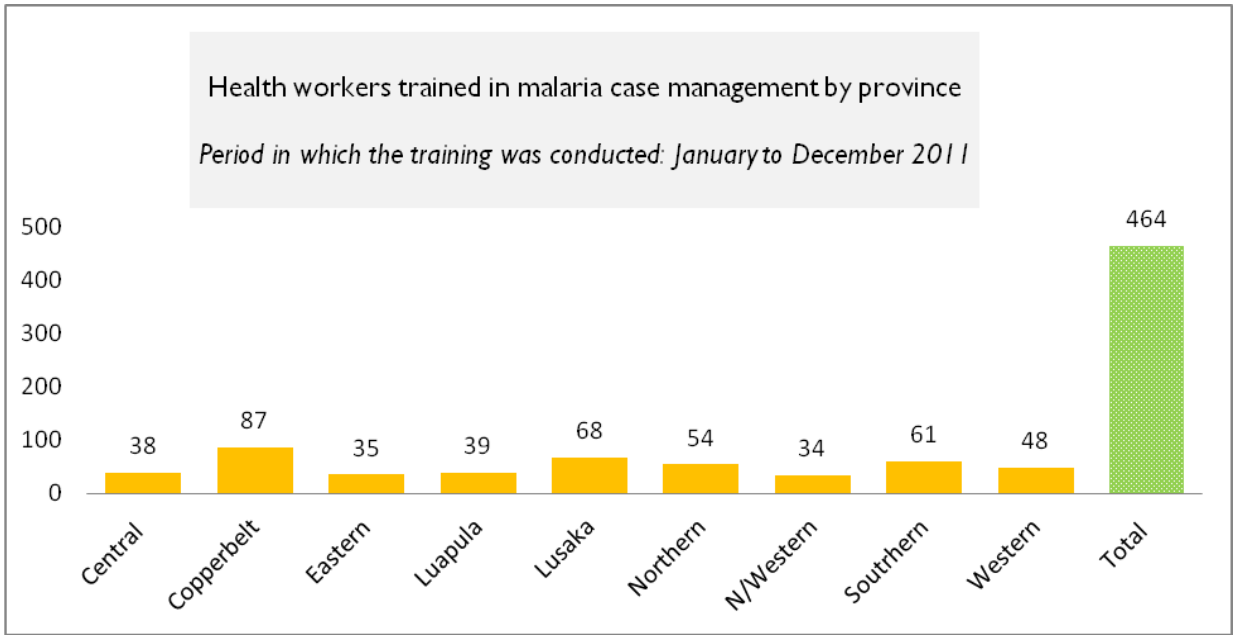
technicians and procuring daily provisions such as washing detergents and sugar. The purpose of the insectary is to provide a source of mosquitoes of known genetic traits and use these mosquitoes in monitoring the quality of spraying, the efficacy of insecticides on walls, and vector resistance.

3.3.11 TRAINING OF HEALTH WORKERS IN REVISED MALARIA GUIDELINES

ZISSP in collaboration with NMCC trained 464 health workers using the revised malaria guidelines. NMCC revised the guidelines for diagnosis and treatment of malaria in Zambia to reflect the updated policy recommendations. These new guidelines are an important reference for general malaria case management. To assist with the training, ZISSP supported NMCC to develop training materials and printed 4,000 copies of the malaria guidelines. These trained health workers will mentor other health workers in their health facilities in correct malaria case management.

A total of 464 health workers consisting of members from the district CCTs, tutors from training institutions and senior clinical officers from district hospitals were oriented to the revised guidelines. Emphasis was placed on proper malaria case diagnosis based on clinical findings and confirming using rapid diagnostic tests (RDTs).

FIGURE 3.3: SHOWS THE NUMBER OF HEALTH WORKERS TRAINED PER PROVINCE



3.3.12 MALARIA IN PREGNANCY ASSESSMENT

According to the malaria indicator survey (MIS 2010), intermittent preventive therapy in pregnancy (IPTp) remains a challenge in some parts of Zambia. In 2011, the MOH received support from ZISSP to conduct a rapid assessment survey on malaria in pregnancy in 18 districts of the nine provinces in Zambia. The results revealed that only 41% of health workers in the selected districts were oriented to focused antenatal care (FANC) within the last two years prior to the survey. As a result, ZISSP supported MOH to train an additional 38 health workers in FANC in Luapula Province. These trained health workers will mentor other health workers in their health facilities in the latest FANC guidelines.

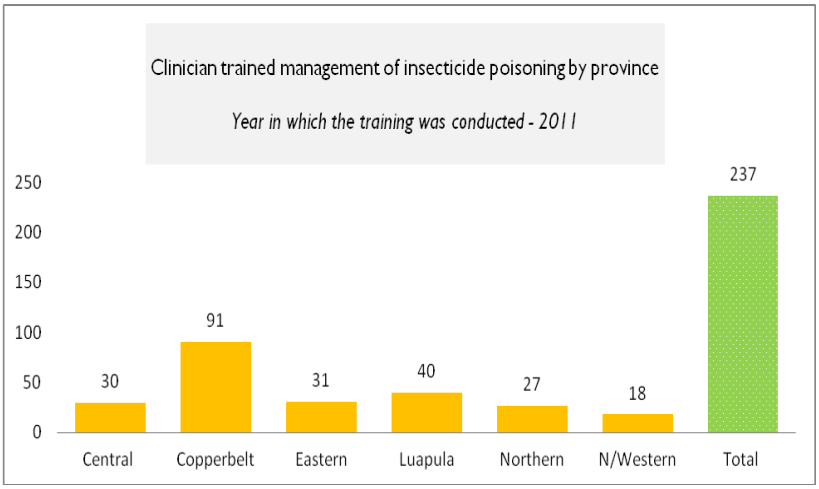
3.3.13 STRENGTHENING LINKAGES BETWEEN HEALTH PROVIDERS AND THE COMMUNITY

ZISSP collaborated with the NMCC and the Reproductive Health Unit of the MOH to develop the malaria in pregnancy module to be added to the Community Health Assistants (CHAs) curriculum. The module focuses on strengthening pregnancy related behavior communication change (BCC) competencies for CHAs. The HMIS report for the last quarter of 2010 indicated that up to 80% of pregnant women do not have contact with health providers in their first trimester. It is therefore important to build on this and strengthen linkages between health services and communities to continually improve family and community practices that strengthen health seeking behavior in pregnancy.

3.3.14 TRAINING OF CLINICIANS IN MANAGEMENT OF INSECTICIDE POISONING

ZISSP assisted the NMCC to develop materials to train clinicians in case management of insecticide poisoning. To speed up implementation, ZISSP hired a consultant to lead the activity. The training materials include a PowerPoint presentation, a participant's manual, a flow chart, and questions for evaluating participants. ZISSP used these materials to train 237 clinicians in Northern, Luapula, North-western, Copperbelt, Eastern and Central Provinces in 2011. The training prepared clinicians to respond to toxic reactions to the insecticides.

FIGURE 3.4: NUMBER OF HEALTH WORKERS TRAINED BY PROVINCE



3.3.15 TRAINING OF COMMUNITY HEALTH VOLUNTEERS IN COMMUNITY CASE MANAGEMENT

In Zambia, studies show that up to 80% of deaths in children under- five years of age may occur at home with little or no contact with health providers, emphasizing the importance of strengthening linkages between health services and communities to support and strengthen community capacity to respond to illness. ZISSP provided financial and technical support to the Child Health Unit of MOH to train 32 trainers, 75 supervisors and 91 Community Health Volunteers (CHVs) in integrated community case management (iCCM) in four target districts (Mkushi, Mwinilunga, Mpika and Mansa).

3.3.16 ACTIVE INFECTION DETECTION

In line with the MOH malaria elimination goal, ZISSP together with the NMCC, PMI, Akros Research and the Lusaka DHO team began enhancing surveillance involving malaria active infection detection (AID) pilot program in Lusaka District. Through AID, patients receiving positive confirmation of malaria at local clinic were followed up through community response whereby community health workers (CHWs) visit the household of the patient and use RDTs to test all family members and neighbors for malaria parasites. In 2011, 600 households were visited and over 1,900 people were tested for malaria. Thirty-three community members were found positive for malaria using RDTs, and 14 of these cases reported neither history of malaria (potential false positive) nor travel outside of Lusaka.

3.3.17 INDOOR RESIDUAL SPRAY TOOL

Zambia has invested heavily in IRS over the past decade and now boasts coverage levels in excess of 35% in urban/peri-urban settings contributing to a significant reduction in the national malaria parasitemia from 22% in 2006 to 16% in 2010 (MIS 2010). Historically, IRS field operators recorded each sprayed house, along with a few limited data elements as a single line item on a paper form. Supervisors would then manually aggregate the data before entering these into a spreadsheet for reporting. Each individual spreadsheet would then be methodically cut-and-pasted into a master spreadsheet document. This slow, labor intensive and error-prone system was only able to collect a limited set of data. To address this issue, ZISSP in collaboration with the NMCC developed an electronic data capture solution and piloted for rapid collection and dissemination of IRS data. IRS operators are individually equipped with a PDA that guides them through collecting necessary data elements including global positioning system (GPS) coordinates for every structure, spray application details, long-lasting insecticidal net (LLIN) usage and previous spray history. Validation rules built into the software ensure that only valid data are entered. Supervisors can review these data at the end of each day, ensuring that data are accurate. Datasets are periodically exported for timely reporting to the district and national levels and allow rapid identification of areas of low spray coverage requiring additional IRS mop-up operations. This robust and expanded data collection method allows fine spatial mapping of spray activities to ensure that IRS applications are as effective and efficient as possible.

The PDA system was designed and deployed in Chibombo district for the 2011spray season. Over 40 spray operators and four Environmental Health Technicians (EHTs) were trained in using the system. Final results will be obtained at the end of the 2011 spray season and will be shared with USAID and MOH for policy change.

3.3.18 ENTOMOLOGICAL SURVEILLANCE SYSTEM

Despite the intensification of vector control programming, entomological surveillance is conducted sporadically in a centralized manner by the NMCC or by partner organizations. This is geographically limited in its coverage and data are intermittently collected. Currently, there is no routine longitudinal surveillance system that monitors the impact of expensive vector control interventions from an entomological perspective.

A conceptual framework based on a phased delivery of individual components of an integrated entomological surveillance system has been designed, along with appropriate supporting tools for districts with on-going vector control activities. Individual components of the overall program include training of new and existing recruits, data management, both intra- and inter-district program performance, and calculation of entomological parameters associated with local malaria transmission. Decentralized program delivery and field level management through the EHTs who are responsible for the management of district based vector control activities. Fifty four (54) EHTs from 18 districts were recruited and have embarked on the training phase of the program. Overall, there was a 33% increase in knowledge amongst EHT training recruits ($P<0.001$). Despite this cadre having no specific background in medical entomology, their management of district-based vector control activities and baseline training outcomes indicate that they are well suited to pilot the integrated entomological surveillance model in 2012. Routine collection of entomological surveillance data will provide an evidence base in which program sustainability together with optimizing the use of district based human resources.

4. TASK THREE: IMPROVE COMMUNITY INVOLVEMENT

4.1 COMMUNITY

4.1.1 COMMUNITY RESOURCE MAPPING

During 2011, ZISSP conducted a community resource mapping study to guide ZISSP in planning community-level interventions through better understanding of how best to involve community groups in the health sector, as well as understanding community-based challenges and capacity building needs. The mapping process collected data from districts, health centers, and communities and specific BCC data at provincial level, focusing on high-impact health programs and activities in communities that are supported by ZISSP. The assessment also explored the structure of community groups relevant to health, understanding their roles and responsibilities, and sought to identify synergies and linkages between community groups and health facilities.

The assessment used a qualitative approach that combined in-depth interviews and focus group discussions. Key findings include: 1) men hold the position of chairperson in Health Center Advisory Committees (HCAC) and Neighborhood Health Committee (NHC) in two of every three instances; 2) staff members at the DHOs and health centers understand the concept of community involvement in the planning process but, due to factors like time, staffing levels and sometimes inadequate resources, have not adequately involved or informed community representatives about how the HCAC and NHCs should participate in planning; and 3) although districts offered most health services, the distance to facilities and quality of such services were still some of the major barriers facing communities in seeking out and using existing health services. Almost all communities cited gaps in the availability of specific services, such as adolescent reproductive health, nutrition, and dental services.

During 2012 the findings from this study will be disseminated to the wider stakeholder audience and will be used to guide development of strategies to address the identified challenges in ZISSP program areas at community level. These will focus on building capacity of community groups for involvement in health activities including planning, BCC, and community-based service delivery to maintain community wellness.

4.1.2 DEVELOPMENT OF COMMUNITY HEALTH PLANNING HANDBOOK

The MOH seeks to provide Zambians with equity of access to cost-effective, quality health care as close to the family as possible. To achieve this vision, the MOH recognizes the role of communities and the importance of involving communities in health planning. In 2011, ZISSP assisted the MOH to revise the planning handbook for health centers, health posts, and communities. As a result the new handbook includes guidelines on how health centers can engage communities in health planning. ZISSP supported the dissemination of the revised community planning handbook to all the districts during the 2011 work planning activities.

4.1.3 TRAINING COMMUNITIES IN THE REVISED PLANNING HANDBOOK

In a continued effort to address gaps in engaging communities in the health planning process, ZISSP and the DHOs collaborated to conduct planning workshops with HCACs and NHCs in 25 of the 27 ZISSP target districts while the remaining two, Mansa and Mbala, to trained in 2012.

The workshops presented the guidelines for engaging communities in planning and emphasized the importance of involving communities in identifying priority health issues, and developing community plans for inclusion in the health center and district plans. ZISSP also conducted orientation workshops for key health personnel in DHOs from 74 districts.

> District Medical Officer, Dr. Kunka, officially closed the meeting but urged participants to utilize the knowledge acquired to come up with timely, ideal and relevant community plans which will address the community's health problems. Dr Kunka stressed the point that problems in communities differ from community to community and so he expects every community to take sufficient time to identify their problems and the causes in order for them to produce goal oriented activities.

Nine districts included community plans in their 2012 - 2014 district plans following the training in community planning which coincided with the preparations of the DHO and health center action plans. The districts included budgets for these activities in their plans, as well as being able to solicit financial support from organizations working within the districts if for some reason, they do not receive government funding. The DHOs' presence during the training of communities was a clear indication of the value placed on communities as an important partner in addressing health issues and source of key health information in developing district plans.

4.1.4 COORDINATION FOR THE IMPLEMENTATION OF SAFE MOTHERHOOD ACTION GROUPS

ZISSP is working closely with the MOH and taking a lead among other collaborating partners to ensure that the Safe Motherhood Action Groups (SMAGs) program is well coordinated and provides a platform to address issues related to safe motherhood and newborn health. The concept of (SMAGs) has yielded some positive results in addressing safe motherhood issues, however, the challenges still exist as demonstrated by few institutional deliveries and mothers not seeking postnatal care within the first six days after delivery. Some factors affecting this situation include community disapproval of male providers which exist, continued recognition of TBAs as key in home deliveries, and having to travel long distances to the rural health centers.

ZISSP supported the MOH to conduct a one-day meeting of organizations and institutions involved in implementing or interested in SMAG activities. The partners described their training methodology and type of materials used in training of SMAGs, their geographic coverage and the degree of saturation, the incentives given to SMAG members where provided, and future scale-up plans. The result of this meeting was the formation of technical sub teams that were tasked to draft key elements of an MOH strategy for repositioning the SMAGs program. The elements of the strategy will include: standardization

of training materials and processes; a supervision and monitoring mechanism; branding of materials for SMAGs; development of BCC methodologies and approaches; scaling-up the program and a proposed package of incentives; and a sustainability plan.

4.1.5 TRAINING OF SAFE MOTHERHOOD ACTION GROUPS

ZISSP initiated the implementation of the new MOH strategy in the 27 target districts. In the last quarter of 2011, ZISSP succeeded in training 131 SMAG members from Kalomo, Luangwa, Luanshya, Mansa and Shangombo districts. The training will strengthen and reinforce the skills of the SMAGs to address maternal health issues within the community. This will also facilitate positive behavior change of pregnant women and involvement of the community in maternal health issues.

4.1.6 BEHAVIOR CHANGE PROGRAM CAPACITY BUILDING

In the third quarter of 2011, ZISSP in collaboration with Communications Support for Health (CSH) and MOH conducted a workshop to train and equip the Community Health Coordinators (CHC), program officers from the Zambia Prevention Care and Treatment (ZPCT II) and from the Support to the HIV/AIDS Response (SHARe) projects with knowledge and skills that will enable them to apply a BCC strategic framework in developing health campaigns, competently managing the process of change interventions including formative research, materials development and planning communication activities. Participants also acquired skills to roll out the behavior change program training to the district health promotion officers and partners at community level.

4.1.7 WORKSHOP ON THE ROLES OF TRADITIONAL LEADERS IN BEHAVIOR CHANGE COMMUNICATION ACTIVITIES

ZISSP supported a workshop in the fourth quarter for 21 Indunas and one chief each from Kalabo, Lukulu, Mongu and Shangombo districts. The objective of the workshop was to review the role of traditional leaders in BCC activities and how they need to plan and participate in community health interventions. The workshop critically reviewed the kind of activities they would promote when addressing malaria issues at community level. A major outcome from the workshop was that all 21 Indunas developed plans for community sensitization on the importance of IRS and other malaria prevention initiatives in Western Province.

4.1.8 MEN'S HEALTH KIT

In 2010, the MOH and Health Communication Partnership (HCP) developed a Men's Health Kit to support a broader approach to male involvement in reproductive health and other health issues. The kit includes flip charts and user manuals. However, the MOH had not yet developed an orientation package to introduce DHOs and PHOs on the use of the kit. ZISSP assisted the MOH in developing an orientation package to enable districts to train health facility staff in the use of the kit. ZISSP also assisted in distributing 450 kits to all provinces and districts during the provincial planning launches in 2011 to those participating in MOH organized meetings and workshops that took place in all provinces and districts. In 2012 the distribution of the remaining men's health kit will continue and in addition they will be orientation of the health workers at the health centre and DHO level on the use of the kits.

4.1.9 DISTANCE RADIO LEARNING PROGRAM

In a continued effort to support SMAGs, ZISSP in collaboration with MOH has been developing a radio distance learning program on key safe motherhood messages that will complement and extend initial training that SMAG members receive. The radio program is a form of continuing education for the SMAGs and provides a channel for transferring additional knowledge and communication skills to SMAG members. This program will also provide timely information to SMAG members, give examples of positive behaviors, and empower SMAG members to describe culturally relevant preventive and promotive practices such as male involvement in safe motherhood, importance of institutional delivery, and the need and importance of health referral services.

ZISSP collaborated with the MOH to conduct a workshop to develop the design document for the Radio Distance Learning (RDL) program for SMAGs. Participants to the workshop included representatives from MOH, SMAGs, community-based organizations, NGOs, UNICEF, UNFPA, USAID-funded health projects, community radio stations, radio production houses and media broadcasters. The workshop participants reached consensus on the content of the design document; the team developed a program format to set the structure of each of the 26 episodes. The MOH draft manual for SMAGs and national policy on maternal, newborn, child health and HIV/AIDS formed the basis for identifying content with each episode focusing on levels of skills building including tools and practices that are useful to SMAGs, such as community mapping, community mobilization, communication skills, planning and recordkeeping. Other key cross-cutting issues will cover gender based violence, male involvement, HIV/AIDS, hygiene, income generating activities, and alcohol abuse. Scripts 1and 2 for the RDL program have been completed and recording commenced. Upon completion of the recording process, a pilot will be conducted before airing

4.1.10 INTERMITTENT PREVENTIVE THERAPY FORMATIVE RESEARCH

ZISSP has been collaborating with the MOH to undertake formative research in support of specific community communication initiatives. At the inception of the project in 2010, the communication specialist conducted a desk review to identify areas of focus to develop communication materials. The review highlighted low uptake of IPTp among pregnant women as an area that would benefit from formative research to understand the current practices, motivators, and barriers related to uptake of IPTp. ZISSP engaged a consultant to conduct the formative research. The report will be ready in the first quarter of 2012.

4.1.11 BEHAVIOR CHANGE COMMUNICATION FRAMEWORK

ZISSP held a four-day workshop to develop a Community BCC Framework. The framework is intended to guide and coordinate the implementation of decentralized, integrated, community-based BCC efforts in Zambia. District Health Promotion Focal Persons and representatives from organizations implementing health communication efforts in Zambia attended the workshop. This framework is based on a review of research, existing health communication strategies and communication assessments. A draft framework has been circulated among the workshop participants for comments and will be finalized and disseminated in the second quarter of 2012.Following dissemination, an orientation is planned for the district health promotion focal point persons.

4.1.12 INVENTORY OF BEHAVIOR CHANGE COMMUNICATION MATERIALS

ZISSP engaged a firm to conduct an inventory of existing BCC materials at provincial, district and community levels in Zambia. This will be shared with stakeholders and used to develop an appropriate community BCC strategy. Information gathered from this exercise will be complementing the community mapping exercise that ZISSP undertook to gain deeper insight into the BCC status at the community level.

4.1.13 SUPPORT TO THE MINISTRY OF HEALTH COMMUNITY HEALTH ASSISTANT PROGRAM

ZISSP supports the MOH in its effort to develop and implement the national strategy for CHWs and build the new cadre of community health assistants (CHAs) in order to bring services closer to families. ZISSP worked with the MOH training unit to review the first CHA's training program curriculum; sequencing of the 11 modules, practical sessions and student performance assessment plan, review of the supervisors manual and tools.

ZISSP played a key role in revising the CHA supervision manual and incorporating the checklist for supervisory visits. ZISSP also helped to review and streamline the role and responsibilities of the CHA to avoid conflicts with the role of NHCs. To help ensure that the CHA training program maintains acceptable standards in its theoretical and practical teaching programs, ZISSP helped and continues to assist with monitoring the whole program. Through monthly supervisory visits, ZISSP provides an advisory role in both classroom and practical training in facilities and communities in which students work. At the national level, ZISSP staff members provided input on the management of the program and strategies for smooth administration and management of human resource issues.

4.1.14 ZAMBIA INTEGRATED SYSTEMS STRENGTHENING PROGRAM GRANTS PROGRAM

The ZISSP grant specialist completed key procedural documents that will guide the implementation of the grants program, the goal of which is to promote use of health services by Zambians. By working closely with MOH and other stakeholders, ZISSP produced the following documents: Grants Manual, Analysis Plan, Annual Program Statement (APS), and the Orientation Package for Grants Support Teams (GSTs).

4.1.15 GRANTS SUPPORT TEAMS

ZISSP in collaboration with the MOH has established GSTs at national, provincial and district levels that is charged with the responsibilities of managing and facilitating key processes in a granting mechanism. The GSTs comprise staff from MOH Headquarters, ZISSP, Provincial Medical Office and District Medical Office, are responsible for appraising and short listing grant applicants for funding and monitoring grant implementation and financial performance. The GSTs were oriented to the key roles and responsibilities using an orientation package developed for this purpose and will be responsible for key steps in the grant process to facilitate local ownership of the grant program.

A total of 98 GST members from all the PHOs and 11 DHOs from the districts participating in the grants program in 2012 were oriented to the grant making process. The districts include Luangwa, Serenje, Mansa, Sinazongwe, Kalomo, Lundazi, Nyimba Mpika, Luanshya, Mwinilunga and Lukulu.

4.1.16 ANNUAL PROGRAM STATEMENT (APS) AND REQUEST FOR APPLICATIONS

During the reporting period, USAID approved the APS. The purpose of the APS is to solicit applications for financial assistance from prospective grantees that require support to implement small and medium sized projects which will contribute directly to the ZISSP grants program's goal of promoting the use of health services by Zambians. The total fund available for 2012 cycle of grant funding is $1.2 million. This is expected to fund 10 to 25 local and international organizations. Organizations can receive between US$25,000 and $100,000 and will be given a period of one year in which to implement their projects.

The APS served as the basis for the Request for Applications (RFA), which was advertised at national, provincial and district levels. At national level, the RFA was advertised in the Post and Times of Zambia newspapers for three days. At the provincial and district levels, the advert was placed in strategic locations for two weeks starting from 12 December, 2011. Over 100 organizations from the 11 target districts expressed interest to participate in the grants program and they will be invited to attend the bidders' meetings, after which they will develop and submit their grant applications.

4.1.17 SUPPORT FOR NATIONAL EVENTS

ZISSP worked closely with the MOH and took the lead among other collaborating partners to ensure that the planning and implementation of major health events achieved their intended objectives. ZISSP support is critical in ensuring that service provision reach communities and that community health groups actively participate in sensitizing and mobilizing the general population for services being offered. National health events on Safe Motherhood Week, National VCT Day, Breast Feeding Week, National Malaria Day, and World AIDS Day, provide an opportunity for the MOH and partners to promote community awareness on diseases that affect the majority of the Zambians and the interventions that the MOH has put in place to address these.

ZISSP in partnership with the MOH planned, organized and implemented related activities that included disseminating key BCC messages based on specific themes through dance, drama, skits, poems, and community radio discussions wherever available. The BCC strategy allowed for communities to be reached with messages that aim at promoting their involvement in health and ensuring appropriate health seeking behaviors.

For example the 2011 theme for Safe Motherhood Week was: *"**Zambia cares, no woman should die while giving life***". The national event launch occurred at the Waitwika Palace in Nakonde District under the leadership of the Honorable Minister of Health with the presence of Her Royal Highness Chieftainess Nawaitwika. ZISSP also supported nine districts to plan and implement related activities. In Nakonde district, 53 SMAG members (37 males and 16 females) received special orientation to conduct door to door sensitization messages during the week. Sensitization messages on safe motherhood practices received a spotlight at sports events such as football and netball, and on radio programs and drama performances.

World AIDS Day was another major event. The 2011theme was: "***Getting to zero new infections*".** ZISSP CHCs collaborated with other partners to ensure coordination of the planning and implementation of activities such as drama performances and radio programs especially where community radio station existed.

5. CROSSCUTTING PROGRAM AND MANAGEMENT SUPPORT

5.1 MONITORING AND EVALUATION

5.1.1 DEVELOPMENT OF THE PERFORMANCE MONITORING AND EVALUATION PLAN

The overarching objective of the monitoring and evaluation (M&E) team is to ensure that program activities are implemented according to the ZISSP work plan and that the necessary program implementation information is captured using standard forms. In order to achieve this objective, ZISSP finalized the Performance Monitoring and Evaluation Plan (PMEP) and ensured that routine data comes from the HMIS. The PMEP includes performance indicators a definition and description for each indicator, data collection process, data sources and frequency of reporting data.

5.1.2 DEVELOPMENT OF THE DATA COLLECTION TOOLS

The M&E unit developed data collection tools for the ZISSP supported training and mentorship activities. The tools include the indicators to be measured to determine the performance of each of the ZISSP programs. Twenty indicators were selected from Investing In People (IIP), Performance Plan Report (PPR), Country Operational Plan (COP) and Malaria Operational Plan (MOP). However, 22 other program indicators were also developed to measure program performance.

5.1.3 DEVELOPMENT OF THE PERFORMANCE MONITORING AND EVALUATION DATABASE

The M&E team created a database to support the PMEP, specifically to track the program achievements against the targets. The electronic data are entered from hard copies submitted by the program staff. The team summarized the PMEP data in a concise tracking sheet that displays achievements against the targets. These data are analyzed and reported as appropriate in the quarterly, semi-annual and annual progress reports for the COP, annual MOP, Operational Plan and portfolio reports to the project's program staff, management and the clients.

5.1.4 WORKING WITH THE MINISTRY OF HEALTH

By design, ZISSP relies on routine data which is collected through the HMIS. In 2011 the M&E team established a strong working relationship with MOH Policy and Planning Directorate's M&E staff to ensure that indicator data is easily accessed from the HMIS and harmonized. Furthermore, the ZISSP M&E team actively participated in the MOH M&E TWG to stay abreast of what is going on in the MOH and with partners.

5.1.5 BASELINE SURVEY

ZISSP will conduct a baseline survey with the purpose of benchmarking the program interventions. In 2011, ZISSP developed Terms of Reference and the draft questionnaire for the baseline and also

identified the consultant to conduct the baseline survey. Although ZISSP program interventions have already started, the project will still have the capacity to collect pre-intervention data, as many indicators rely on HMIS data and other existing health statistics, for which we will have access to historical data (2010). For indicators that do not rely on HMIS data, the consultant will also utilize select qualitative approaches to ascertain the situation in 2010, although there will be limitations based on availability of information, and/or interviewee recall.

ZISSP is currently finalizing contractual details with the consultant, and expects the baseline survey process to be fielded in Q1 2012, with a final report available in Q2 2012.

5.1.6 QUARTERLY, SEMI, ANNUAL, PORTFOLIO AND PEPFAR REPORT

During 2011, the M&E Unit led the process of organizing and coordinating the quarterly, semi and annual reports to submit to USAID. These reports provide quarterly, semi and annual updates of the activities which have been done during a specific designated time period. The Monitoring and Evaluation unit also coordinated the development, presentation and submission of the portfolio and PEPFAR reports to USAID. These reports provide program achievements for the reporting period and guide program management.

5.1.7 QUARTERLY REVIEW MEETINGS

The M&E Unit led the process of organizing and coordinating the ZISSP quarterly events to review implementation of the program work plans, providing an opportunity for staff to review the past performance and plan for continuing and/or follow up of activities.

5.1.8 ANNUAL WORKPLAN AND BUDGETS

The M&E Unit provided technical guidance in developing program activities to ensure that program indicators relate to planned activities. The work planning process provides an opportunity for program staff to understand their indicators and how these relate to their proposed activities, data sources and how the data will be collected to measure progress of their activities.

5.1.9 RESEARCH ACTIVITIES

ZISSP worked with the MOH to conduct six research activities: Reach Every Child in Every District (RED) strategy assessment, malaria in pregnancy assessment, community mapping, IPT formative research, Direct Entry Midwifery program assessment and evaluation of community nutrition programs. The purpose of conducting these studies was to provide information to ZISSP and the MOH for planning in high impact health program areas such as HIV/AIDS, family planning, malaria and maternal/neonatal/child health and nutrition.

5.2 KNOWLEDGE MANAGEMENT

5.2.1 TECHNICAL BRIEFS AND SUCCESS STORIES

ZISSP developed technical briefs and success stories in different technical areas (malaria, family planning, maternal, newborn, child health and nutrition) to demonstrate to the client impact of program implementation. Refer to section seven.

5.2.2 INFORMATION SHARING AND TOOLS

The Knowledge Management Unit introduced the following information transfer systems among staff: NX Lite compression software for shrinking electronic files before transmission, and the Dropbox for sending automatic updates of shared electronic files. This approach has simplified the access of information by ZISSP provincial staff by downloading the reports from the specific websites.

5.2.3 STAFF PROFILES

The project developed personnel profiles of all ZISSP staff. This collection of Biodata of all project staff gives a brief description of each staff members' academic and professional qualifications, competencies and experience for internal and external use.

5.3 CAPACITY BUILDING

5.3.1 DEVELOPING TRAINING CURRICULA

The M&E Unit of the ZISSP program has provided technical guidance across all ZISSP program areas in developing training curricula and related guidance to ensure standard trainings exist. In clinical care, ZISSP developed operational guidelines and reviewed the training materials for quality improvement and clinical mentorship, while in reproductive health, the project facilitated the review of the family planning and CBD training curricula.

5.3.2 PROVIDING ON- SITE GUIDANCE DURING TRAINING

The Capacity Building Specialist provided on-site coaching to MOH trainers to ensure that all training and methods used are consistent with modern adult learning approaches such as participatory learning and action, and brain storming to problem solving. On-site coaching was conducted in malaria and EmONC. In malaria, on-site coaching was carried out in all the nine provinces where 464 health workers were trained in the revised malaria guidelines. In EmONC on-site coaching was conducted for existing national trainers who trained a total of 135 health workers in 2011.

5.3.3 COMMUNITY HEALTH ASSISTANTS PROGRAM

ZISSP is mandated to provide continuous supervision on the newly introduced Community Health Assistant (CHA) program. ZISSP assisted the program management team to develop the student academic progression regulations. This is a set of guidelines that govern how students are recruited, placed and monitored throughout their study period. The Capacity Building Specialist further provided technical assistance in the structural improvement and implementation of student training at facility and community levels.

5.3.4 GENDER INTEGRATION

ZISSP worked with its sub-contractor the Center for Development and Population Activities (CEDPA) to develop a gender strategy to be incorporated throughout ZISSP's program areas. The strategy will provide guidance to address health related gender inequities and maximize both men's and women's contributions to improved health within the ZISSP planned activities. The gender strategy is designed to

outline steps ZISSP can take to mainstream gender considerations into its programming in order to make its programming more gender sensitive and better address gender issues that inhibit the project from reaching its expected outcome of improving the utilization of health interventions.

5.4 FINANCE AND ADMINISTRATION

During 2011, ZISSP's Finance and Administration Department strengthened internal operational systems to improve on program delivery and accountability. The Department:

- Introduced more detailed and transparent systems for the payment of allowances and reimbursements during trainings and workshops and provided refresher training in expense reporting to all staff;
- Improved quality of documentation for financial transactions (ROVs) by introducing a clear work schedule to ensure timely financial reporting;
- Established a vendor database and introduced preparation of Local Purchase Orders in-house to minimize delays in the procurement process and consequently project implementation;
- Introduced stringent measures on management of activity advances to improve on reported burn rates and increase accountability;
- Introduced mobile time reporting;
- Revised administrative procedure manuals to include human resources aspects;
- Implemented a Geo-tab Fleet System to improve on vehicle usage through live monitoring of vehicle movement;
- Introduced an online transport booking system to ensure proper planning and availability of transport for timely project implementation;
- Initiated the implementation of a more cost effective and efficient system of fuel procurement and usage.

5.5 OVERALL BUDGET AND EXPENDITURES

As of December 31, 2011, ZISSP spent a cumulative total of $19,585,066.07 against current obligations of $26,270,555.00. Cumulatively, ZISSP had spent 22.2% of the total project estimated amount of $88,092,613.

5.6 HUMAN RESOURCES

ZISSP has a total of 103 staff including four senior management staff, 56 technical staff, 18 finance and administrative staff and 25 drivers. In 2011 the project recruited 40 technical and administrative staff.

ZISSP is in the process of recruiting two CCSs for Luapula and Eastern Provinces, one Communications Specialist and two District Coordinators for the Saving Mothers Giving Life Initiative in Mansa and Lundazi districts.

5.7 MAJOR CHALLENGES AND RESPONSE

CHALLENGES	STEPS TAKEN TO ADRESS CHALLENGES
▪ MOH delaying the release of operational funds for the 2011 IRS season which led to late initiation of IRS activities by districts including the ZISSP IRS districts.	▪ The PMI announced that it would be able to fund operational costs of IRS from in 2012 and beyond
▪ Difficulty in filling vacancies in some key positions such as the CCSs.	▪ Finance and administration continued to identify candidates within and outside Zambia.
▪ ZISSP's inability to pay out-of-pocket allowances during training leading to cancellation or postponement of some training activities.	▪ ZISSP to conduct training using DSA in areas where this is feasible.

6. FOCUS AREAS FOR 2012

Below are included key activities planned for by each of the major ZISSP technical programs areas.

MATERNAL, CHILD HEALTH AND NUTRITION, FAMILY PLANNING, AND HUMAN RESOURCES

- Build HR management capacity
- Enhance the existing HRIS to include more data and to generate the required HRH management information system reports
- Continue to support the retention scheme as well as conduct monitoring and evaluation of the retention scheme
- Conduct training in LTFP, CBDs, EmONC, IMCI, IYCF, CBGMP, mentorship and the RED strategy
- Review and finalize national newborn care guidelines
- Conduct assessments in maternal and child health to identify and respond to gaps in pediatric HIV
- Strengthen implementation of integrated child health interventions
- Support NFNC to develop guidelines on Scaling Up Nutrition
- Review EmONC training progress in training schools and EmONC sites
- Develop a supportive supervision system for EmONC training sites
- Develop facility and community misoprostol guidelines and implementation plan
- Conduct a national EmONC impact survey
- Conduct EmONC site and equipment needs assessment
- Conduct rapid assessment of the impact of LTFP training
- Support implementation of the ADH strategy
- Develop ADH communication strategy
- Review and adapt ADH training materials for facility health workers
- Conduct a needs assessment on youth friendly health services
- Review safe spaces curriculum for schools and communities

MALARIA

- Conduct training in IRS, insecticide poisoning, malaria case management, FANC, iCCM and IRS logistics
- Review and develop strategic documents and tools for IRS, FANC, and IPTp
- Develop the M&E newsletters
- Incinerate insecticide waste and transport IRS commodities
- Expand the insectary
- Conduct entomological investigations, IRS needs assessment and active case surveillance
- Support BCC for malaria
- Conduct monitoring and supervision during the 2012 spray season
- Conduct enumeration of housing structures in selected districts

QUALITY IMPROVEMENT AND CLINICAL CARE

- Strengthen mentorship to improve CCM at all levels
- Institutionalize quality improvement across clinical care programs at all levels in order to improve the quality of patient treatment outcomes

- Support the MOH 2013-2015 planning cycle at all levels
- Document best practices and innovations and outcomes of the quality improvement program, e.g., clinical mentorship
- Strengthen system measures or innovations that will support DHOs in improving the quality of the clinical care program

COMMUNITY HEALTH COORDINATORS

- Build capacity of MOH staff at district and facility level to engage communities in health activities
- Develop and print materials to guide activity implementation at district and community levels, e.g., for 1) SMAGs training and supervision and 2) materials and guidelines for community participation into health activities including the BCC framework
- Provide financial and technical support to MOH in repositioning SMAGs in at least 18 districts
- Strengthen the implementation of the CHA program through capacity building of tutors and strengthening the M&E and supervisory system for this program
- Implement the grants program in 11 districts
- Conduct inventory of BCC materials
- Implement the RDL and conduct RDL assessments
- Develop strategic plan for drama capacity building
- Conduct IRS formative research
- Strengthen involvement of traditional, faith-based , and other opinion leaders as change agents

MANAGEMENT SPECIALISTS

- Continue to provide technical assistance to stakeholder meetings and initiate establishing local steering committees in the provinces and districts to strengthen partnerships at these levels
- Provide routine support to MOH planning process at all levels
- Provide technical assistance to PHOs to develop provincial Statistics Bulletins to improve data management and usage at provincial and district levels
- Provide technical assistance to MOH to complete revisions and to implement the revised PA tools for all levels
- Provide technical assistance to MOH for implementing resource mapping (tracking tool)

MONITORING AND EVALUATION

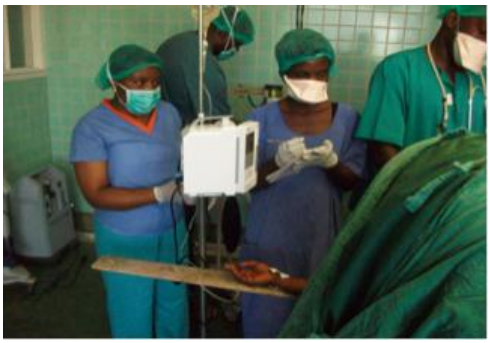
- Finalize the reviewed PMEP
- Conduct the baseline survey
- Finalize the annual budget and the work plan
- Conduct the Direct Entry Midwifery Schools assessment review
- Conduct demographic health survey activities.

7. SUCCESS STORIES

7.1 DECENTRALIZING SERVICE DELIVERY THROUGH SURGICAL AND ANESTHETIC SKILLS TRANSFER, LESSONS FROM CENTRAL PROVINCE

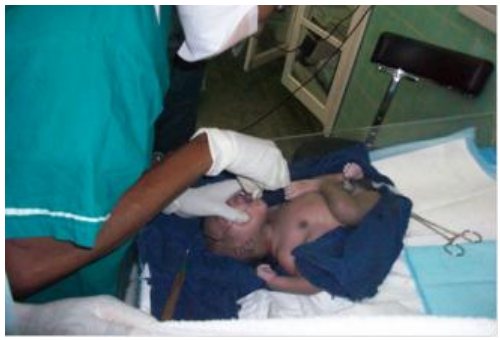
Until recently, the district hospitals in Central province were challenged by a critical shortage of skilled personnel to administer anesthesia, hindering the provision of surgical interventions for those in need. As a result, most patients were referred to Kabwe General Hospital and other tertiary hospitals for surgery, forcing them to travel long distances and delay accessing care. This led to unfavorable outcomes such as maternal and neonatal deaths. The increased number of referrals also exerted pressure on maternity, surgical and theatre staff at Kabwe General Hospital. Districts were also spending significant funding on fuel and allowances for staff to accompany the referred patients.

In September 2011, the Clinical Care Specialists at the Central Provincial Health Office (PHO), the Provincial Surgeon at Kabwe General Hospital and two lecturers from Lusaka School of Anesthesia met to discuss opportunities to strengthen surgical capacity at the district level. Out of this meeting, the team developed a one week didactic training package to be followed by a two-week intensive mentorship session focusing on intravenous and spinal anesthesia, resuscitation of the newborns and adults, and obstetric and surgical skills.



Two mentees take notes as their mentor demonstrates a surgical procedure during the two-week intensive mentorship session.

In collaboration with the Central PHO, the USAID-funded Zambia Integrated System Strengthening Program (ZISSP) provided financial and technical support in the training and mentoring of 29 health workers from nine hospitals in basic anesthesia and surgical skills. The trained participants included medical officers, medical licentiates, nurses, and clinical officers. Clinicians received a refresher course in surgical skills while nurses focused on basic anesthetic skills. The initial one-week didactic training and subsequent two-week intensive mentorship session took place at Kabwe General Hospital. The mentees were then visited at their hospitals after three months for more mentoring by professional mentors from the PHO and the Lusaka School of Anesthesia.



A mentee receives hands-on practical experience as she clears a newborn's airway under the guidance of a mentor at Kabwe General Hospital.

As a result of this initiative, Serenje District Hospital, which had not been conducting major surgeries for years, performed its first emergency caesarean section on November 26, 2011. After less than two months had passed, the hospital had performed a total of 17 caesarean sections. Previously, the hospital referred surgical patients to Chitambo Mission Hospital, which is approximately 87 km from Serenje. Dr.

Swali, Medical Officer in-charge at Serenje District Hospital and Acting District Medical Officer happily explains, "We have stopped budgeting for referrals to Chitambo Mission Hospital. We are doing surgical operations here and we are now saving money…our two nurses that were oriented in basic anaesthesia are doing a good job." Through this initiative, health worker capacity has been strengthened, the work load burden on tertiary and mission hospitals has been reduced, and district hospitals are now able to provide life serving surgical interventions closer to their communities more cost -effectively.

7.2 NUTRITION TRAINING OF COMMUNITY VOLUNTEERS PAYING OFF

According to Zambia Demographic Health Survey (ZDHS) in 2009) childhood stunting rates were 45%, underweight rates were 24% and wasting 5%. In an effort to contribute to reduction of childhood malnutrition rates, the Ministry of Health in collaboration with Zambia Integrated Systems Strengthening Program (ZISSP) has been engaged in training health workers and community members in Community Infant and Young Child Feeding (CIYCF) integrating it with Community Based Growth Monitoring and Promotion (CBGMP).

Between June and September 2011, ZISSP supported the Ministry of Health to train 150 community members in CIYCF and CBGMP.

Following the training, the Community Health Promoters/Volunteers (CHPs/Vs) participated in outreach weighing services in their communities. They were amazingly startled at the number of children having static weight for periods of 2-3 months range, apart from those who are being identified as underweight.

Having been empowered with skills, attitudes and knowledge to provide nutrition counseling to mothers with young children, these volunteers counseled mothers one on one and enrolled them into cooking demonstrations to learn how to enrich a child's diet using locally available foods and have also made appropriate referrals to health facilities located in the area. Within a period of 2 months post training, the CHVs were able to identify over 749 underweight children out of 3,500 under-five children assessed in 25 communities in 5 districts of North Western, Copperbelt, and Northern provinces. The volunteers did all this without formal means of transportation such as bicycles!

7.3 RAPID DIAGNOSTIC TESTS (RDTS) USE INCREASES IN KITWE DISTRICT

Adherence to case management guidelines in light of the move to strengthen laboratory diagnosis of malaria using Rapid Diagnostic Tests and microscopy remains a challenge for many health workers. The practice has been that malaria was clinically diagnosed using fever coupled with suggestive signs and symptoms as a basis for starting treatment. The National Malaria Control Centre (NMCC) made revisions to the Guidelines for Diagnosis and Treatment of Malaria in Zambia to reflect the updated policy recommendations and therefore improve the case management in malaria.

It is against this background that in February 2011, the USAID funded Zambia Integrated Systems Strengthening Program (ZISSP) collaborated with NMCC to print 4,000 of the revised malaria guidelines and orient health workers.

Kitwe District is one of the districts with high malaria burden in Zambia. According to the HMIS data for 2010, Kitwe reported 160,784 clinical (unconfirmed) which were treated with antimalarials (Artemisinin –Lumefantrine). The cost of one dose of antimalarial is about 12 US dollars.

Lab Technician Bertha Mwiinga Mwale at Buchi clinic conducts a malaria test using an RDT. Bertha is one of the health workers trained in malaria case management.

Kitwe District is one of the beneficiaries of the PMI support through ZISSP. In 2011, ZISSP supported NMCC to orient twenty (20) health workers consisting of members from the district clinical care teams, tutors from training institutions and senior clinicians from Kitwe Central Hospital to the revised guidelines. Consequently ninety (90) frontline health workers in Kitwe were trained in malaria case management and emphasis was placed on proper malaria case diagnosis based on the clinical findings and confirming using RDTs with support from ZISSP. Furthermore, ZISSP supported the district to revive the Malaria Task Force-Case Management Subcommittee, whose mandate is to ensure proper malaria case management. The committee has also developed and implemented guidelines to ensure that only confirmed cases are treated with antimalarials.

After implementation of the above measures, Kitwe District has recorded an increase in the confirmed cases and a reduction in the unconfirmed cases. According to the 2011 HIMS data, Kitwe reported 129,719 unconfirmed cases. The use of antimalarials has also reduced by about 30,000 doses in 2011.

7.4 ZISSP RESPONDS TO COMMUNITY REQUESTS FOR IMPROVED SAFE MOTHERHOOD IN MIBENGE AND NDOBA

In September 2011, two Safe Motherhood Action Groups (SMAGs) from the remote areas surrounding Mibenge and Ndoba Rural Health Centers in Luapula Province met to discuss their interest in seeking training for their members. SMAGs at Ndoba had not been trained but organized themselves to sensitizing mothers to deliver at the health centre while the group at Mibenge needed to increase the number of trained members in their SMAG. This group of committed men and women recognized the need for improving safe motherhood practices in their communities and took the initiative to learn how they could help. The group sought informal instruction from a few peers who had received formal SMAG training. With this basic knowledge, they were able to carry out some of the SMAG roles and responsibilities, but realized that with formal training they could do much more.

'Finally the health workers in our district have started trusting the Rapid Diagnostic Tests (RDTs) and the use of antimalarial medicines on the unconfirmed cases has reduced drastically. Money will be saved by this practice and the funds saved from this can be used to improve other key health priorities in Kitwe' – Kitwe District Pharmacist- Nalishebo Mwila Siyandi

Supporting the Ministry of Health in strengthening the SMAG program in Zambia, representatives of the USAID-funded Zambia Integrated Service Strengthening Program (ZISSP) traveled to Luapula Province to determine the status of maternal health in the area. The team spoke to local residents of Mibenge who expressed the need to increase the number of trained SMAG members in the community. The ZISSP team also met the untrained SMAG members at Ndoba Regional Health Center (RHC), who demonstrated their understanding of the SMAG program and the positive impact that they were having in their communities through drama performances, song, and dance. They also expressed their desire for formal SMAG training to maximize their abilities to improve maternal health in their communities. The visiting ZISSP team quickly responded to the needs of the Mibenge and Ndoba communities by mobilizing resources to train the 50 untrained SMAG members.

SMAG members from Mibenge and Ndoba participate in an interactive discussion during the ZISSP-supported SMAG training in October 2011.

Since the training in October 2011, some key maternal indicators are beginning to show a positive change. The number of facility deliveries at Ndoba RHC has increased from 56 in 3rd quarter to 82 in 4th quarter. Euphrasia Chibwe, a newly trained SMAG member at Ndoba RHC said, "We are very happy for the training and as a community, we have begun to see results". She noted that before training (3rd quarter, 2011) the centre had documented 51 home deliveries as compared to 37 home deliveries after the training (4th quarter, 2011). Facility staff have also witnessed an increase in male involvement evidenced by the number of male partners that escort the pregnant women to seek services. The number of women escorted by their male partner increased from approximately 66% before the training to 83% after the training.

In Zambia, SMAG members are a bridge between communities and the health centers. SMAG members take behavior change messages that promote families and couples to attend and utilize reproductive health services to communities. The aim of such activities is to contribute towards the reduction in maternal, child, and neonatal morbidity and mortality. As part of the ZISSP mandate, the project is supporting efforts to strengthen the implementation of SMAG activities through capacity building trainings and the provision of equipment and supplies for SMAG members.

7.5 ORIENTATION TO HEALTH PLANNING PROVES BENEFICIAL FOR PROVINCIAL HEALTH OFFICE STAFF IN THE EASTERN PROVINCE

Despite many years of investing in health planning, the Ministry of Health (MOH) has continued to face many challenges with the quality of service delivery at all levels of the health care system. To support the MOH in addressing such challenges, the USAID-funded Zambia Integrated Services Strengthening Program (ZISSP) has continued to collaborate with the MOH to build provincial and district/hospital level capacity in the area of planning. In May 2011, ZISSP's Eastern Province Management Specialist provided technical support to the Provincial Health Office (PHO) to conduct training for programme officers on the basics of planning. The training focused on prioritization, budgeting, and implementation.

During the training, participants were introduced to the ABC system and Pareto Analysis, methodologies which promote systematic prioritization of interventions during the planning process to ensure high impact results during implementation. The ABC system promotes categorization of health interventions in order of priority from most to least important. Pareto Analysis emphasizes the need for programme officers to identify which 20% of the planned interventions, if implemented, could assist them to attain 80% of the required performance levels, especially in a resource constrained environment.

George K. Mulenga, HR Development Officer for the Eastern Province PHO actively participates in a capacity building workshop to improve health planning skills.

One of the training participants was George K. Mulenga, who has been working as a Human Resource (HR) Development Officer at the Eastern PHO for the past five years. Prior to the training, Mulenga explains that, "I never used to look at my work plan and review what I have done and not done."

Since the training, Mulenga has since improved his work performance by applying some of the new concepts he learned in his day-to-day activities. Mulenga explains, "After the orientation, I work systematically, I plan my work, put them in order of importance, and at the end of the day check how much each [activity] has contributed to [the] achievement of my job description and set objectives of the department and the province as a whole." With these new skills, Mulenga and other workshop participants will be able to more efficiently implement HR related activities at the provincial level.

ZISSP will continue to support the MOH through similar training programs and on site coaching and mentoring to district/hospital staff during the MOH annual planning process.

8. ANNEXES

ANNEX A: ZISSP ACHIEVEMENTS: JANUARY 1, 2011 TO DECEMBER 31, 2011

#	Indicator	Work Plan		Annual Achievements (January–December 11)			
		Targets (June 10 – December 14)	Targets (October 2010 – September 2011)	Achievements (January – December 2011)	Male	Female	Total
1	Proportion of the health care workers supported through the ZHWRS in 27 target districts retained for the first and second year (cohort)	119	119	117	77	40	117
2	Number of facility providers trained in FP/RH counseling, service delivery, and/or guidelines	192	82	37	21	16	37
3	Number of community-based providers trained in FP/RH counseling, service delivery, and/or guidelines	TBD	540	0	0	0	0
	Number of health care facility providers trained in maternal/newborn health….[i]	540	80	200	76	59	135
	Number of community health volunteers trained in maternal/ newborn health….[ii]	729,000 [iii]	N/A	374	221	153	374
	Number of children under 12 months of age who received DPT3 from USG-supported programs	2,047,000	398,000	512,000 (as of June 2011)	NA	NA	NA
	Number of children under 5 years of age who received Vitamin A from USG-supported programs	12,350,000	2,383,000	1,893,467 (as of June 2011)	NA	NA	NA
	Number of community-level health workers trained in child health and nutrition	TBD	120	288	189	99	288
	Number of health care providers trained in child health care and child nutrition through USG-supported health area programs	432	96	607	261	346	607
	Number of housing units and structures sprayed with IRS with USG funds	2,300,000	1,459,948	Data by March 2012	-	-	-

#	Indicator	Work Plan		Annual Achievements (January–December 11)			
		Targets (June 10 – December 14)	Targets (October 2010 – September 2011)	Achievements (January – December 2011)	Male	Female	Total
	Proportion of targeted structures sprayed with IRS with USG funds	85%	85%	Data by March 2012	-	-	-
	Number of women who have completed a pregnancy in the last two years that received two or more doses of IPTp	85%	75%	MIS data in 2012	-	-	-
	Proportion of children under 5 years with suspected malaria that received treatment with ACT within 24 hours of onset of their symptoms	70%	40%	MIS data in 2012	-	-	-
	Proportion of households with at least one ITN and/or sprayed with IRS in the last 12 months	85%	80%	MIS data in 2012	-	-	-
	Number of health workers trained in malaria case management with USG funds	TBD	360	627	395	232	627
	Number of health workers trained in FANC	TBD	360	38	14	24	38
	Number of people (PMOs, DMOs, Drivers, store keepers, IRS supervisors and spray operators) who have been trained with USG funds to deliver IRS (disaggregated by type of training)	13,567	2,396	1,888 [v]	1279	609	1888
	Number of community health workers or volunteers trained in malaria case management or prevention with USG funds	1,296	540	77	70	7	77
	Number of health care workers that successfully complete an in-service training program within the reporting period (clinical mentoring sessions disaggregated by gender)	2,400[v]	600	1083[vi]	528	473	1001[vii]
	Number of health care workers that successfully complete an in-service training program within the reporting period (management and leadership, planning, HR –PMP, data quality by gender) **HSS**[viii]	800	240	626	389	237	626

[i] ZISSP originally had an indicator in its PMP for training of providers in EmONC in ZISSP districts. USAID later requested that ZISSP add this indicator to satisfy Mission indicator reporting requirements. As a result, ZISSP should replace the original indicator with this indicator to eliminate double counting.

[ii] ZISSP's original indicator focused on training community members as SMAG members. USAID later requested that ZISSP add this indicator to satisfy Mission indicator reporting requirements. As a result, ZISSP should replace the original indicator with this indicator to eliminate double counting.

[iii] This indicator should replace the one above it on training of community members in HBLSS / SMAGs.

[v] Performance looks low because the target for the number of people trained was set based upon the assumption that ZISSP would work in 54 districts. PMI later requested that ZISSP focus only on 35 districts.

[i]The target of 2,400 is for fiscal year of October 2011 to September 2012.
[ii] The total 1,083, represents the mentorship sessions not individuals.
[iii] The total 1,001 represents the actual individuals who were mentored.
[iv] Health Systems Strengthening

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